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ABSTRACT

This guide presents profiles of 26 state, regional, and local programs that have been effective in meeting the needs of students with emotional/behavioral disabilities and their families. Each of the programs reflects in varying degrees the care value, principles, and framework developed by the Child and Adolescent Service System Program (CASSP). This model stresses the values of child-centered, community-based approaches to intervention. Individual program descriptions include a program overview, a discussion of the program and its services, sources of further information, and the name and address of a contact person. Model programs discussed include the following: Alaska Youth Initiative; Bertha Abess Children's Center Comprehensive Day Treatment Program; Cities in Schools--Seattle; Classroom Companions; Community Outreach Program for Education (COPE); Comprehensive Community-Based Continuum of Care in Butte and Ventura Counties (California); Connections Initiative; Empowering Families and Schools; Facilitating Integrated Interagency Services for Seriously Emotionally Disturbed Children in Nashua (New Hampshire); Family Mosaic Project; Georgia Psychoeducational Network; Iowa City Collaborative Integration Project; Kaleidoscope; Kentucky Bluegrass IMPACT; Linn County (Oregon) Youth Service Teams; Partners Project; Partnership for Family Preservation: Children and Adolescents Network of Dupage County (Illinois); Primary Mental Health Project; Project Connect; Project WRAP; Regional Intervention Program; SEDNET (Multiagency Service Network for Students with Severe Emotional Disturbance); Southern Westchester (New York) IDT (Intensive Day Treatment) Program; Stark County (Ohio) System of Care; Ventura County (California) Mental Health Children and Adolescent Project; and Vermont New Directions. Appendices provide additional details for 11 of the programs. (Contains 33 references.) (DB)

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Organizing Systems to Support Competent Social Behavior in Children and Youth

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ED 380 972

Model Programs and Services

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TABLE OF CONTENTS

Introduction iii

Model Programs

Alaska Youth Initiative 1

Bertha Abess Children's Center
Comprehensive Day Treatment Program 7

Cities in Schools — Seattle 11

Classroom Companions 15

Community Outreach Program for Education (COPE) 19

Comprehensive Community-Based Continuum of Care
in Butte and Ventura Counties 23

Connections Initiative 29

Empowering Families and Schools 33

Facilitating Integrated Interagency Services for Seriously
Emotionally Disturbed Children in Nashua, NH 37

Family Mosaic Project 41

Georgia Psychoeducational Network 45

Iowa City Collaborative Integration Project 47

Kaleidoscope 49

Kentucky Bluegrass IMPACT 53

Linn County Youth Service Teams 57

Partners Project 61

Partnership for Family Preservation:
Children and Adolescents Network of Dupage County 63

Primary Mental Health Project 65

Project Connect 69

Project WRAP 73

Regional Intervention Program 77

SEDNET (Multiagency Service Network for Students
with Severe Emotional Disturbance) 81

Southern Westchester IDT (Intensive Day Treatment) Program 83

Stark County System of Care 85

Ventura County Mental Health Children and Adolescent Project 91

Vermont New Directions 97

References 101

Appendices

A. Introduction 105
B. Alaska Youth Initiative 121
C. Cities in Schools 139
D. Iowa City Collaborative Integration Project 143
E. Kaleidoscope 151
F. Linn County Youth Service Teams 167
G. Partners Project 183
H. Partnership for Family Preservation 199
I. Project WRAP 205
J. Southern Westchester IDT (Intensive Day Treatment) Program 217
K. Stark County System of Care 221
L. Ventura County Mental Health Children and Adolescent Project 253

INTRODUCTION

Model Programs and Services is the second in a series of documents with the theme *Organizing Systems to Support Competent Social Behavior in Children and Youth* to be published by the WRRC. Upcoming titles in the same series include *Prevention, Interventions,* and *Teacher Stress and Burnout*. The series examines current thinking and identifies successful strategies for:

- Promoting good mental health and socially acceptable behaviors among students;
- Preventing the development of emotional/behavioral disabilities and student involvement in gangs and violent actions by using strategies such as screening and early intervention, schoolwide discipline plans, and positive alternatives to violence and gang activities;
- Developing programs to meet the needs of students with emotional/behavioral disabilities as well as those at risk for developing these disabilities at the district, building, and classroom level; and
- Addressing the issues of stress and burnout among teachers who work with students with emotional/behavioral disabilities.

This series is part of a multi-state activity developed by the Western Regional Resource Center in response to state directors in Region 6, who voiced a need for more effective strategies to meet the needs of students identified as having emotional/behavioral disabilities. These are students who generally have the "worst outcomes of any group of students across a number of critical measures" (Koyanagi & Gaines, 1993, pp. 2 - 3). As a group, students with emotional/behavioral disabilities do not perform well academically. They typically have higher drop out rates, lower grades, more homebound instruction, and more restrictive placements than their peers. For many students, emotional and behavioral problems are compounded by family issues. Many of them are "at high risk of school, and indeed life failure as a function of poverty, parental substance abuse, violence or mental illness" (Knitzer, 1990, Executive Summary, p. xi).

If the needs of children at risk for emotional/behavioral problems are not addressed while they are young, these children may later develop emotional and/or behavioral disabilities. As these children grow older, their problems do not disappear but instead "reverberate through the family and throughout the community" (Koyanagi & Gaines, 1993, p. 17). Because these young adults often do not continue their education and frequently fail to find or keep jobs, many of them become part of the adult mental health system, criminal justice system, and/or welfare system, thereby draining public resources.

Region 6 Special Education Directors have indicated a need for information about effective strategies for meeting the needs of students identified as emotionally/behaviorally disabled and programs designed to prevent the development of emotional/behavioral disabilities. These strategies include early assessment and intervention, programs that have succeeded in curbing violence and gang activity in schools, and ideas for providing support and resources to teachers working with students with emotional/behavioral disabilities to help prevent the inevitable stress and burnout that accompanies the job.

The concerns expressed by the SEA Directors in Region 6 are not unique to the western region of the country. Although responses to a 1993 survey of SEA Directors concerning critical information needs conducted by the National Association of State Directors of Special Education (NASDSE, 1993) showed great variation among the six regions of the country, information on how to cope with violent and aggressive behavior was ranked as the No. 1 issue among SEA directors nationally. Also ranked in the top five among 97 different information needs was the identification of successful models/practices for providing for the needs of students with severe behavioral and emotional disorders.

Model Programs and Services presents profiles of 26 state, regional and local programs that have been effective in meeting the needs of students with emotional/behavioral disabilities and their families. Some of these, such as the Georgia Psychoeducational Network, Ventura County System of Care, Regional Intervention Program, and Kaleidoscope, have provided services to children and youth and their families for more than a decade. Others, such as Project WRAP and the Iowa City Collaborative Integration Project, are more recently funded programs that have added distinctive strategies to a foundation based on classic models.

Model Programs and Services was written with the realization that there exists no ideal program that will magically solve the myriad of problems faced by students today with emotional/behavioral disabilities. What works in Alaska may not work in Arizona; what proves effective in Guam may not be successful in Idaho. It is our hope that the programs profiled here will present an array of innovative ideas and approaches that can be adapted to fit the individual needs of different regions and populations across the country. This document is intended as a sharing of the best and most current strategies being used to meet the needs of students with emotional/behavioral disabilities and their families.

Although the programs profiled here vary, they all share a common core of basic values and operational philosophies that guides their service approach and delivery. Each of these programs reflects in varied degrees the landmark system of care values, principles, and framework developed by the Child and Adolescent Service System Program (CASSP) in 1986 (Stroul & Friedman). This model has served as a starting point and guide for many individual states and communities building systems of care to meet the needs of students with disabilities and their families.

THE CASSP SYSTEM OF CARE MODEL

In her landmark study *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*, Jane Knitzer (1982) described the current state of mental health care for children as "dismal." Her study indicated that two million children who were seriously emotionally disturbed were not receiving the services they needed. As the result of Knitzer's study, a combined federal and state initiative was developed to direct increased attention and improve services for children with emotional disabilities and their families. CASSP was born of this initiative and works with states to promote leadership in the area of children's mental health and to develop multi-agency capacity for serving children and families.

The CASSP model was developed by Stroul and Friedman (1986) as "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents" (Executive Summary, p. iv). Two core values are central to the system of care and its operation. The first value is that the system of care must be child centered, with the needs of the family determining the services provided. The authors elaborate on the value of a child-centered approach:

> This child-centered focus is seen as a commitment to adapt services to the child and family, rather than expecting children and families to conform to pre-existing service configurations. It is also seen as a commitment to providing services in an environment and a manner that enhances the personal dignity of children and families, respects their wishes and individual goals, and maximizes opportunities for involvement and self-determination in the planning and delivery of services. (Executive Summary, p. vi)

The second core value states that the system of care should be community based, "with the locus of services as well as management and decision-making responsibility resting at the community level" (Stroul & Friedman, 1986, Executive Summary, p. vii). This value reflects a commitment to providing services in community-based programs which provide less restrictive, more normative environments than traditional, restrictive facilities.

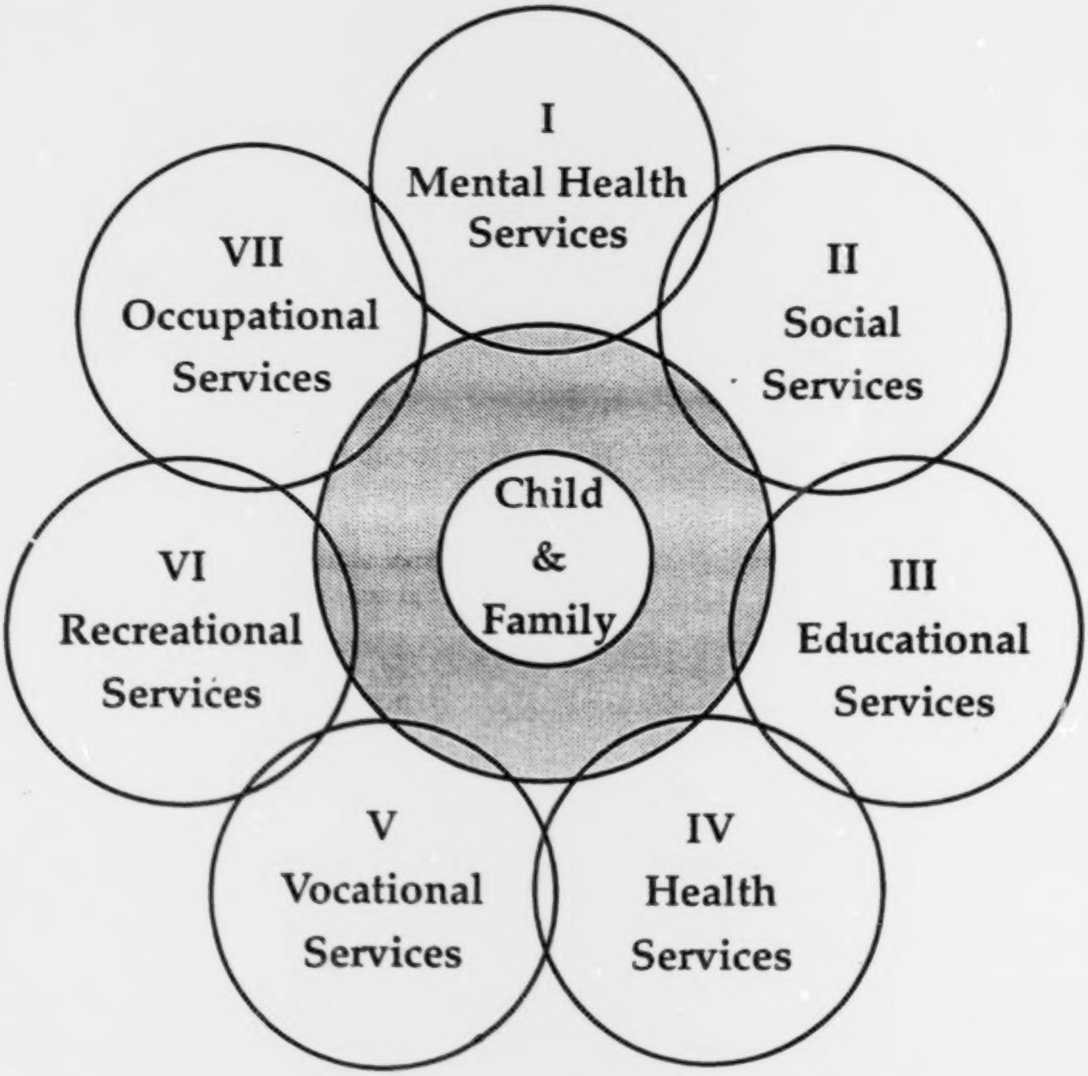
Building on these fundamental values, Stroul and Friedman (1986) set forth the following ten guiding principles for the system:

- Children and youth with emotional disabilities should have access to a comprehensive array of services that address physical, emotional, social, and educational needs;
- Children and youth should receive individualized services in accordance with their unique needs and potentials, guided by an individualized service plan;

- Children and youth should receive services in the least restrictive, most normative environment that is clinically appropriate;
- Families and surrogate families should be full participants in all aspects of planning and service delivery;
- Children and youth should receive integrated services that are linked to other appropriate agencies and programs;
- Children and youth should be provided case management services to ensure the coordination of multiple services designed to meet their changing needs;
- Early identification and intervention should be promoted by the system of care;
- Adolescents should be ensured smooth transitions to the adult service system;
- Rights of children and youth with emotional disabilities should be advocated for and protected;
- Children and youth should receive services "without regard to race, religion, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs." (Executive Summary, p. vii)

The system of care model designed by Stroul and Friedman (1986) identifies seven major dimensions of service which revolve around the child and family (see diagram on page vii). The seven dimensions are 1) mental health services, 2) social services, 3) educational services, 4) health services, 5) vocational services, 6) recreational services, and 7) operational services. According to the authors, the model is intended to be "function-specific rather than agency-specific. Each service dimension addresses an area of need for children and families, a set of functions that must be fulfilled in order to provide comprehensive services to meet those needs. The model is not intended to specify which type of agency should meet particular needs" (Executive Summary, p. viii). The authors caution that their model is "not a prescription" but a guide for communities, adopted "with the expectation that it will be modified and adapted to meet special conditions and needs" (Executive Summary, p. viii).

System of Care Framework


I
Mental Health Services
II
Social Services
III
Educational Services
IV
Health Services
V
Vocational Services
VI
Recreational Services
VII
Occupational Services
Child & Family

RELATED MODELS OF CARE

More recent studies have strengthened and confirmed the CASSP model originated by Stroul and Friedman by making similar recommendations and by extending the original model. Additionally, states such as Vermont, Kentucky, California, and Virginia have passed legislation that incorporates this model or variations of the model into their own state system of care.

In "Children's Mental Health: Challenges for the Nineties," Duchnowski and Friedman (1990) identified seven major challenges to the children's mental health field which need to be addressed to achieve the vision of an effective service delivery system. Those challenges are:

- To bridge the gap between university-based training programs and actual needs of youth with emotional disabilities and their families;
- To continue to improve interagency coordination efforts;
- To increase the research base related to the mental health needs of children and their families;
- To continue to reconceptualize the system of care as a "dynamic concept still in its infancy both in terms of its conceptual development and its actual implementation." Issues these authors say need to be considered include incorporating individualized treatment into the system, using families as allies in the treatment and system-building process, and developing a culturally competent system;
- To strengthen the advocacy movement for improved services for youth with emotional disabilities and their families;
- To achieve an adequate level of funding for children's mental health services and develop appropriate funding policies; and
- To create appropriate services for children at risk for developing emotional disabilities.

In *All Systems Failure* (1993), the National Mental Health Association recommends the following actions be taken to improve services to children and youth with emotional disabilities:

- Create a wider array of school and mental health system services to meet the needs of children with serious emotional disturbance;

- Provide services and supports that strengthen and maintain the family unit and encourage the view that parents are partners in planning for their children's needs, not the source of their children's failure; and
- Develop collaborative arrangements between schools and mental health systems, in particular expanding mental health services within the schools. (Koyanagi & Gaines, 1993, p. 3)

The National Agenda for Achieving Better Results for Children and Youth With Serious Emotional Disturbance (1994) lists the following seven "strategic targets" for improving services for children and youth with serious emotional disturbance.

- Expand positive learning opportunities and results
- Strengthen school and community capacity
- Value and address diversity
- Collaborate with families
- Promote appropriate assessment
- Provide ongoing skill development and support
- Create comprehensive and collaborative systems

The National Agenda for Achieving Better Results for Children and Youth With Serious Emotional Disturbance (1994) has been reproduced in Appendix A.

Issues and Options for Creating Comprehensive School Linked Services for Children And Youth With Emotional or Behavioral Disorders (1994) explores four options for improving services to children and youth with emotional and behavioral disabilities. These options are:

- To create a flexible system of services across agencies, disciplines, and settings
- To create a service support system that includes families
- To establish outcomes for students that reflect broad educational and treatment goals
- To improve the training of educational personnel

In addition to these studies, a 1993 survey of administrators and program leaders in 14 states identified and prioritized key features of an Individualized Assistance Approach to service delivery for students with emotional disabilities (MacFarquhar, Dowrick & Risley, 1993). Based on the responses gathered, the authors developed this prioritized list:

1) Program services must be tailored to fit the youth, not the youth fit into the existing services;
2) Services must be youth and family centered;
3) Funding needs to be flexible to permit flexibility in programming;
4) Programs must work under an unconditional care policy;
5) Use of a treatment team for collaborative planning and management is a must;
6) Normalization should be stressed throughout all phases of treatment planning and implementation;
7) Programs should use a community-based care approach;
8) Intensive case management is essential;
9) Funding must be extensive enough to provide whatever services are needed for significant effect with an individual;
10) Treatment planning and implementation must strive towards less restrictive alternatives;
11) An accountability component is essential; and
12) Services should be based on appropriate outcome data. (p. 169)

COMMON ELEMENTS OF MODEL PROGRAMS

Child-centered, family-focused services. The CASSP values and guiding principles developed by Stroul and Friedman (1986) form the philosophical core of the programs profiled here. Services provided in these programs are child centered and family focused. The services prescribed in the individual treatment plans are designed to adapt to the needs of children and their families rather than to force them to conform to pre-existing service systems. Treatment plans created by interdisciplinary teams focus on the strengths of the family rather than on pathology. Individualized services may include both traditional forms of intervention as well as non-traditional approaches and are carefully planned to address basic human needs that everyone experiences. Treatment takes place at school, in the home, and in the community; support services are offered to both the child and to the family. Families are considered a vital part of the planning and treatment plan and are invited to be equal partners in the process. In fact, in the Iowa City Collaborative Integration Project parents are trained to serve as their own case managers. Youth are also included as members of the team whenever possible.

Similarly, the Comprehensive Community-Based Continuum of Care in Butte and Ventura Counties, California is seeking to create services that are not only family focused but "family friendly" by encouraging "genuine collaboration" between parents and agencies serving youth and their families.

Community-based services. Services provided to children and youth and their families are also community based, as recommended by the CASSP model, with localized management and control. Programs attempt to provide services in the least restrictive, most normative environment using natural supports that already exist in the community. Although these programs recognize that some children require hospitalization, they also believe that most children have a better chance of doing their best when they receive care at or near their home, surrounded by a loving family and a supportive community.

Programs such as the Alaska Youth Initiative have succeeded in bringing to a halt costly out-of-state placements for students with emotional disabilities. Many programs ascribe to the concept of "normalization," which asserts children learn best if they live and learn in a family or family-like environment in their own community. Several programs "wrap" services around the needs of the family and have adopted a similar attitude to Stark County, Ohio's commitment to do "whatever it takes!" to make a difference.

Interagency collaboration. The systems of care profiled here are based on the premise that no agency can be as effective individually as it can be when working with other agencies. No single agency has the ability or resources to meet all the needs of children and their families. Therefore, most of them have adopted an integrated approach that links agencies and provides mechanisms for planning, developing and coordinating services. These agencies often pool their services, resources, and dollars to coordinate services and minimize duplication.

The integration of services requires careful case management, a component found in most of the programs included here. Case managers help families plan and develop individualized treatment plans and revise them as their needs change. Case managers help families navigate complex service systems, link families to neighborhood-based resources and social supports, coordinate services on an ongoing basis, and purchase mental health services. Case managers working side by side with teachers in school settings are also able to forge partnerships as allies for the same cause.

Prevention/early intervention. Prevention and early intervention are recognized as important elements of several of these programs. The recognition that as early as preschool it is important to identify children at-risk and provide individualized treatment and support has translated into programs such as those identified here in the

Stark County System of Care, Georgia Psychoeducational Network, and Bertha Abess Children's Center profiles.

DISTINCTIVE FEATURES OF MODEL PROGRAMS

Although these programs have common approaches and philosophies, each project also reflects the needs and priorities of the population it serves. For instance, The Iowa City Collaborative Integration Project has an automated strategy used to "flag" students at risk for developing emotional disabilities so that interventions can be started earlier in hopes of deterring more significant problems. In Idaho, the Classroom Companions program uses paraprofessionals who provide one-on-one day treatment support for students. Art therapy is considered an important part of the treatment milieu offered to students in Florida served by The Bertha Abess Children's Center, Inc. And in Albuquerque, the Empowering Families and Schools project focuses on the need for family involvement in treatment strategies for students with emotional and behavioral problems.

Illinois' Project WRAP has the distinction of being the most inclusionary of all the programs profiled here for providing services to students with emotional disabilities in regular school settings.

IDENTIFICATION OF MODEL PROGRAMS

We used several strategies to identify the model programs profiled here. The authors of *At the Schoolhouse Door* (Knitzer, Steinberg, & Fleisch, 1990) examined the ways schools and mental health agencies were cooperating to meet the needs of students with emotional/behavioral disabilities. During program reviews, interviews and site visits, these authors identified promising programs and practices. Some of the programs included in this document were identified during that study. Others are grant recipients in the Robert Wood Johnson Foundation's Mental Health Services Program for Youth. Still others are community system of care programs identified by CASSP as having developed a balanced array of residential and nonresidential services, succeeded in "putting some basic building blocks into place," and demonstrated "progress toward achieving system development goals" (*Profiles of Local*, 1992, p. ii-iv). The Multi-agency Service Network for Students with Severe Emotional Disturbance (SEDNET) and the Georgia Psychoeducational Network are state initiatives supported mainly by state dollars. And grants awarded by the United States Department of Education support several programs such as Project Wrap and the Iowa City Collaborative Integration Project.

Inclusion of a program in this document is not intended as an unqualified endorsement by the Western Regional Resource Center, but rather recognition of serious efforts to provide innovative services to this most at-risk population. Other programs worthy of inclusion in this document may have been overlooked. We welcome suggestions for additions.

PROGRAM PROFILES

Each of the 26 program profiles that follow in alphabetical order includes an overview of the program, and, where available, the program's philosophy, a description of the program and services offered, staffing information, funding information, an evaluation of effectiveness, and a program contact.

In writing this document the term "youth" has been used to include both children and adolescents. Where the term "him" or "his" has been used, the term refers to youth of both genders.

Supplementary information on many of these programs is included in the appendices. Additional information about specific programs can be obtained by contacting the project contact listed in each section or the Western Regional Resource Center.

Alaska Youth Initiative

ALASKA YOUTH INITIATIVE

AYI staff members stay with youths, retrieve youths, negotiate with youths, and stand up for youths through the most difficult times; in short, they refuse to give up.

OVERVIEW

The Alaska Youth Initiative (AYI) began in 1985, as staff members in the Alaska State Departments of Education and Health and Social Services realized that increasing numbers of students with emotional disabilities were being sent out of state. This practice was considered a problem for a variety of reasons, including cost, questionable results, and legal and ethical issues (VanDenBerg, 1989). In response, the Department of Education, the Division of Family and Youth Services, and the Division of Mental Health and Developmental Disabilities joined together to form the Interdepartmental Team (IDT) to address their concerns. This team began to search for alternative ways and means to treat and educate this population of children and youth within the state.

Adopting the philosophy of unconditional care, individualized programs, and normalized services from the Chicago-based Kaleidoscope program (profiled on pages 49 - 51 of this document), the IDT proposed to return to Alaska as many youth as possible who were receiving out-of-state residential services and to prevent others from leaving. With the same funds that originally paid for out-of-state services, the IDT began developing case-managed, flexibly funded, wrapped around, family-centered services that were tailored to meet the individual needs of youth while they remained in their own families and community schools. This effort came to be known as the Alaska Youth Initiative. The AYI has become a classic model for coordinating services for youth with emotional disabilities, and is replicated in various forms across the country.

At the same time that leaders of the Child and Adolescent Service System Program (CASSP) movement were searching for ways to take the current system of component-based services and transform it into a flexible, integrated system, the Alaska Youth Initiative experimented with applying the wraparound service philosophy to an interagency state program for youth with emotional disabilities. Alaska "offered a practical alternative to the traditional service approach. Within the individualized approach, the traditional service components would become pieces that would fit into the individual service mosaic constructed to meet the full range of needs of each child and his or her family" (Burchard, Burchard, Sewell, & VanDenBerg, 1993, p. v).

The initial goals of the Alaska Youth Initiative were to limit further institutional and out-of-state placements, to transition back to Alaska the youth already placed out of state, and to provide individualized case planning, monitoring, program development, and funding for youth and their families. As these goals were met, the AYI began focusing on preventing out-of-region placements as well and expanding its mission with two additional goals. The first of these was to produce demonstrable improvement in the level of functioning and quality of life for each youth in the program while providing services in the least restrictive environment. The second goal was to identify and demonstrate effective practices of individualized services and disseminate these practices to other service providers.

Although Alaska has not integrated its services to these youth and their families at the local or state level as fully as some of the other programs described in this document, the state is engaging in collaboration, cooperation, and planning. AYI staff members have developed a saying: "If the adults don't agree, the youth fails" (AYI, 1989, p. 26).

PHILOSOPHY

The Alaska Youth Initiative has adopted a philosophy of unconditional care so that no youth is ever rejected or ejected. In other words, the AYI program accepts each youth regardless of past behaviors and will not discharge any youth from the program, regardless of behaviors. Program staff members attempt to fit services to youths and their changing needs rather than either trying to fit youths to the service or referring them to other services. This unconditional care commitment means that staff members support youths through even the most difficult times; in short, they refuse to give up. Through this process, staff members develop a mutual, trusting relationship with youths they serve which helps to minimize multiple placements (Burchard, Burchard, Sewell, & VanDenBerg, 1993, p. 22).

In the evaluative study *One Kid at a Time* (Burchard, Burchard, Sewell, & VanDenBerg, 1993), the authors further explain the AYI philosophy:

> The AYI approach allows children and their families to live the most normalized lives possible: lives which are controlled by their strengths rather than by their problems. Even if an AYI child must ultimately be institutionalized, the child, family, and community have had an equal opportunity to learn the power of an unconditional approach and a positive, strength-based attitude. It is within this context that AYI has pushed communities to resist restrictive placement and to struggle with meeting the needs of their young people at home. (Foreword, p. iv)

PROGRAM/SERVICES

A Core Service Team, comprised of representatives of mental health, social service, and education, the youth (depending upon his age and maturity), his parents, and other individuals important in the youth's life, meet to carefully assess the needs of each youth and family across eight basic life domains: educational, family, legal, medical, psychological, recreational, social, and vocational. Drawing from this information, team members brainstorm creative ideas, uninhibited by cost or practicality, in an attempt to formulate an ideal solution. If there is no possible way to implement the ideal, team members then "work backwards" from that point to what solutions are realistic as they develop and prioritize individualized plans and solutions to each youth/family's problems. Since funding is flexible, a variety of community resources can be used as part of the treatment plan. Placing a youth interested in fishing with a commercial fisherman or purchasing a snowmobile are not considered unusual uses of AYI resources.

Team members understand that many of the youths have been accepted into the program because traditional service options and placements have failed and that they must be innovative to help many youths succeed. The Core Services team meets as often as necessary to monitor and modify the service plan; progress is reviewed on a quarterly basis.

Because the cities and regions of Alaska are so different, the types of treatment plans and modes of service delivery vary considerably across the state. Despite their variations, all the plans are drafted according to ten principles of individualized care, which guide the planning, implementation, monitoring, and modification process (Burchard, Burchard, Sewell, & VanDenBerg, 1993, pp. 151 - 162):

1) Building and maintaining normative lifestyles;
2) Ensuring that services are client-centered;
3) Providing unconditional care;
4) Planning for the long term;
5) Working toward least restrictive alternatives;
6) Achieving provider competencies;
7) Establishing consensus among key decision makers;
8) Funding services with flexible budgets;
9) Installing a 'gatekeeper' function; and
10) Developing measurable accountability.

A more detailed description of each of these principles has been reprinted in Appendix B.

In most cases each youth has a behavioral contract or contingency management plan that provides structure and limits for behavior at home and at school in order to help him develop self-control and responsible behavior.

STAFFING

The Alaska Youth Initiative is staffed by a state coordinator and 12 local coordinators in key locations around the state. The local coordinators implement treatment plans and help youth transition between services and placements. AYI also relies heavily on the use of aides to work with youth within their families, in alternative placements, in regular school or special education programs, and in recreation settings. Working with flexible schedules, these aides offer extra support needed by families, foster families, and programs to retain youth in their communities. Part of the money allotted for services to each child and youth in the program is also used for staff training.

FUNDING

Initially, funds which formerly supported out-of-state placements were used to begin community-based services for youth in the program. It was decided that the funds would "follow the children" but could be used flexibly for whatever services were considered appropriate. As youth referrals to the program began to increase, funding could not keep pace with need. At present, mental health, child welfare, and special education pool their resources to support youth served by the program. AYI is also seeking other sources of funding such as Medicaid and federal grants to allow for expansion and ensure service to all eligible youth.

The use of flexible funding enables the Core Services Team to use monies in any way that makes sense within the treatment plan. Team members can appeal for more funds should the treatment plan change in a way that raises costs. Flexible funding allows the team to quickly purchase services such as tutoring or emergency respite care during critical times, often preventing the need to move the youth to a more restrictive program.

EVALUATION

The Alaska Youth Initiative has succeeded in reversing the trend of out-of-state placements, although not all youths in the program are able to live in their natural homes. AYI has brought to a virtual halt the former practice of placing youth in restrictive settings out of the state. At the same time the state has developed individualized services that have been effective in keeping youth in their communities.

In One *Kid at a Time* (Burchard, Burchard, Sewell, & VanDenBerg, 1993), the authors present an evaluative description of the Alaska Youth Initiative and the impact it has had on the lives of ten children and adolescents served by the program between 1986 and 1991 for whom other interventions, including out-of-state residential care, had failed. The case histories described in this document demonstrate the unconditional approach used by AYI. When decisions made by the Core Services Team prove ineffective, steps are retraced and another approach is tried. Each failure offers more information to the team and helps team members to define a service approach that will be effective. "Often what works is very nontraditional," writes Ira Lourie in the Forward, "and, on occasion, even bizarre" (Burchard, Burchard, Sewell, & VanDenBerg, 1993, p. vi).

In nine out of ten cases reviewed in *One Kid at a Time* (Burchard, Burchard, Sewell, & VanDenBerg, 1993), AYI had been successful in stabilizing the behavior of the youth within normalized community settings, eliminating runaway behavior, and eliminating or reducing acting-out behaviors. Five youths received educational services in regular school settings while four older adolescents earned their General Education Diplomas (GED).

As a result of AYI's experience with individualized services, community mental health centers and other child serving agencies are beginning to adopt the process of individualized care in their communities.

ADDITIONAL INFORMATION

More detailed information about the Alaska Youth Initiative is included in Appendix B.

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Bertha Abess Children's Center Comprehensive Day Treatment Program

BERTHA ABESS CHILDREN'S CENTER
COMPREHENSIVE DAY TREATMENT PROGRAM

Affective education is provided through various therapy techniques, including art therapy, and is considered part of the treatment day.

OVERVIEW

The Bertha Abess Children's Center, Inc. is a non-profit, charitable corporation that has served youth with disabilities since 1962. Through a cooperative agreement with Dade and Monroe County schools, the Department of Health and Rehabilitation Services, the University of Miami School of Medicine, the Public Health Trust, and the Multiagency Service Network for Severely Emotionally Disturbed Students (SEDNET), this project contracts with the Bertha Abess Children's Center to provide comprehensive, multidisciplinary day treatment services to children and youth ages 3 through 21 in several area schools.

According to literature provided by the project, the goals of the program are to "identify behaviors that interfere with successful functioning in the school and community and to minimize or remediate the behaviors that are inappropriate to learning and successful daily living."

PROGRAM/SERVICES

The Center provides a comprehensive psychoeducational day treatment program designed to meet the individual needs of each student. Active participation of parents in the planning and review of the individual plan is encouraged. The program model has three phases:

- diagnostic—assessment and program planning
- prescriptive—implementation of the treatment plan
- transitional setting—preparation for returning to the mainstream

According to information published by the Bertha Abess Children's Center, "this phased model affects all areas of the student's psychoeducational plan. In behavioral areas, the student moves from low-level reinforcers (tangible) to high-level reinforcers (praise, grades). Academic tasks change from game-oriented, teacher-dependent tasks to more traditional textbook assignments which are taught in group lessons. Social/emotional skills move from simple sharing of materials and labeling feelings to more disclosing and less structured group sessions."

In highly structured classroom settings, two trained instructional staff members work with groups of eight to ten students. Techniques used with students include sequential behavioral interventions, systematic positive behavior management, environmental manipulation, and a variety of instructional modalities. Affective education is provided through various therapy techniques and is considered part of the treatment day.

In the secondary program, students may take regular education classes. Additionally, the program offers career awareness, career lab, social skills, and life management to prepare students for future independent living.

Clinical staff members provide individual and group therapy, including art therapy. Project literature describes the goals of these therapeutic services as the following:

- To increase self awareness
  —acknowledge progress and accept praise
  —utilize criticism constructively
  —increase ability to evaluate self

- To develop social skills
  —develop daily-living skills and socially appropriate behaviors
  —become aware of responsibilities
  —learn to deal appropriately with different situations and systems

- To increase self esteem
  —learn to participate in numerous small group activities
  —learn to acknowledge and delight in achievements of self and others

- To improve functioning in the home and community
  —learn to function more comfortably within the family
  —increase awareness of family and community dynamics

Once students are ready to transfer to regular school settings, the Center works closely with the school system to assure the best placement. Center staff maintain contact with transitioning students on an ongoing basis for five years.

Parents or adults providing care for youth served by the program are provided parent training and education, support groups, and outreach family therapy. Additionally, clinicians provide families with resource planning services and intervention techniques in home management. "A basic premise of our program," project literature points out, "is the belief that a student's progress in the program is greatly enhanced by the involvement and support of the family unit."

STAFFING

In addition to education and mental health staff members, a full-time clinical psychologist supervises the clinical program, provides evaluations and consultations as needed, and coordinates staff training. Psychologists from the public schools provide psychological evaluations. The University of Miami School of Medicine provides psychiatric evaluations and consultation. Additionally, practicum students and interns from nearby universities provide therapy, psychological evaluations, and social services.

FUNDING

Funding for the project is multi-based through participating agencies, SEDNET, and private donations.

EVALUATION

According to information provided by Bertha Abess Children's Center, most of the students participating in this program would be in residential treatment if the day treatment program were not available.

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Cities in Schools - Seattle

CITIES IN SCHOOLS—SEATTLE

"We are a catalyst for change to make the system work for kids and their families."

OVERVIEW

Cities in Schools (CIS), founded during the 1960s as a program for dropouts in Harlem, is one of the nation's most comprehensive, non-profit prevention programs for students at risk, including those with emotional disabilities. Cities in Schools (CIS) reverses the traditional model of students seeking services outside of school. In this program, as the name implies, the city and its resources are brought into the school where the students are. At the school site, cooperating agencies work together to provide children and youth with direct access to social, health, mental health, and educational services.

The Cities in Schools program has been replicated in 384 educational sites throughout the country. These programs vary with the needs of students in the area and operate under different configurations of private/public funding support. In Region 6, Cities in Schools programs are currently operating in Anchorage, AK; Coolidge, AZ; Compton, CA; Inglewood, CA; Long Beach, CA; Los Angeles, CA; Sacramento, CA; Honolulu, HI; and Seattle, WA.

In Texas, the Cities in Schools program has been successfully incorporated into state legislation that guarantees a certain level of state funding through the Texas Education Agency budget allocation each year. Each of the state's 500 school campuses currently receives $50,000 per year in state funds.

The Seattle Cities in Schools program began in 1991. The 25 members who serve on the CIS Board of Advisors represent the community, the city, the county, the state, the school district, the parents, unions, the private sector, United Way, and the justice system. According to program literature, the board "acts as stakeholders in the future of children and youth and represents the resource, service, and institutions needed to alleviate the needs of at-risk children, youth, and their families, providing them the opportunities to manage their own destinies."

To set up a new program, CIS uses an eight-step strategic program development process that establishes:

- State city, and/or county CIS Board of Advisors;
- A management capacity;
- Interagency agreements;
- Agency participation agreements;
- Volunteer mentor and tutor programs;
- School site implementation plan;
- Evaluation system; and
- Secure funding.

An ongoing strategy of collaboration links the Board of Advisors with agencies, schools, and volunteers.

PHILOSOPHY

The national vision of Cities in Schools states that: "Every child is a gift. Every child has gifts to give. It takes all of us to create a vision that allows all kids to be successful." This vision is supported by the CIS mission statement, which reads, "We are a catalyst for change to make the system work for kids and their families."

The vision of the Seattle CIS program expresses hope that "all at-risk children and youth, including their families, will have access to social, health, and other appropriate services that are necessary to improve quality of education, employment, and standards of living" (*Cities*, 1991, p. 3). The Seattle CIS strategic plan developed in July of 1992 describes an even more ambitious vision:

> Imagine this: Each child in the City of Seattle with their own individualized personal plan; collaboratively developed by the state's leaders, students and parents; with existing resources optimally marshaled from our extensive public, private, and community based service network. These services are targeted to help achieve the goals identified.
>
> Every child knows they are surrounded by a team of caring adults. Everyone in the community understands the goals and objectives and their role in achieving them. We start with students most in need and move out from there. The programs and strategies currently in place with demonstrated success will be there as a stable resource for 20 years with incremental new developments added. (It takes, 1992, p. 2)

PROGRAM/SERVICES

On the local level, CIS brings together local government, school officials, social service agencies, and private business representatives to form a board of directors. The board assesses the community's needs and resources and establishes projects at educational sites throughout the community.

At each of the 26 elementary, middle school, and high school sites in Seattle, a Student Intervention Team of 6 to 12 school and community agency representatives decides what services are needed by students referred to the program by their teachers or parents. A project coordinator who serves one to three schools, depending on student enrollment at those sites, acts as the student and parents' link to services provided through the CIS network. Resources and services which the project coordinator "brokers in" provide support to meet the needs of the students and their families. Some of these services are provided on campus; in other instances, students go off campus to receive services. Tutors, mentors, social workers, job skills specialists, and substance abuse counselors usually provide supplemental services. These may include counseling, health services, employment training, job placement, recreation services, court advocacy, anger management, nutrition services, parent education, public assistance, private assistance, and crisis intervention. CIS service providers such as social workers and health specialists collaborate with teachers to effect positive changes in students' behavior, academic performance, and attitudes and raise their self-esteem.

A major strategy of the CIS program is to provide tutor/mentor relationships for students through volunteer coordination. The Cities in Schools project encourages the formation of personal relationships between students and caring adults. The project believes that "no other single factor is as important in redirecting the lives of disconnected youth as a one-to-one relationship with a caring adult."

FUNDING

The Seattle CIS program receives both private and public support. CIS also receives United Way funding support.

ADDITIONAL INFORMATION

Additional information outlining the Cities in School strategy, services, and organization has been reprinted in Appendix C.

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Classroom Companions

CLASSROOM COMPANIONS

Paraprofessional Classroom Companions provide one-to-one support and assistance to students both in and out of school.

OVERVIEW

The Classroom Companions Program began in Boundary County, Idaho as an individualized community-based intervention to prevent restrictive placements of students with emotional and/or behavioral disabilities. Original funding was provided through a Child and Adolescent Service System Program (CASSP) grant; the program is now supported by participating agencies providing localized services. Classroom Companions has continued in this original site and has been successfully replicated in several areas of the state. Sites for the program vary as the intervention is set up for individual students rather than being a school-based program.

The service provides support and advocacy on an individual basis for youth with emotional and/or behavioral disabilities by using one-to-one paraprofessional Classroom Companions. The service is designed to prevent out-of-state, out-of-community, out-of-school, and out-of-home placements. Services to students are determined by individual needs. Use of Companions expands the support, supervision and case management capabilities of the school and allows students to remain in regular education settings. The service is offered through a joint agreement between Family and Children's Services (FAC) and local education districts, who are the ones responsible for implementing the program. Clinical support and backup is provided by the local Family and Children's Services staff. Active coordination and cooperation with other community resources is also part of the program.

PHILOSOPHY

Health & Welfare program objectives of the Classroom Companion Program are:

1. To sustain children and adolescents with persistent emotional and/or behavioral problems in family, community or school settings and, over time, to improve their general level of functioning;

2. To delay the need for or reduce the length of out-of family or out-of-community placements of these children and to increase their community tenure;

3. To enhance the child's quality of life through an individual supportive relationship;

4. To improve the child's access to and linkages with needed community resources, agencies and services;

5. To foster a trusting relationship and responsibility through a companion role model for the child;

6. To expand the local FACS case management capacity through the utilization of non-professional supportive care workers;

7. To reduce stigma relating to emotional or behavioral problems through community member involvement as classroom Companions;

8. To develop collaborative efforts within the community in the provision of services to emotionally/behaviorally disturbed children and adolescents.

9. To assist parents and caretakers in accessing relevant community resources.

School district objectives for the program are:

1. to maintain high risk students in the classroom setting;

2. to provide one-to-one support for identified students to aid in achieving their optimum level of academic and behavioral performance;

3. to provide support for the general classroom teacher and the student's classmates;

4. to reduce the number of events requiring disciplinary action outside the classroom;

5. to increase the student's social and behavioral acceptance with peers;

6. to increase the student's opportunity for success in order to increase self esteem; and

7. to coordinate with parents to maximize family involvement.

PROGRAM/SERVICES

Classroom Companions provide relevant classroom services, outreach, follow-up, case management assistance, and other supportive care services under the joint supervision and clinical support of the coordinating school social worker and the FACS supervising case manager. Each companion is assigned one to three students for whom he or she provides a total of 40 hours of classroom, transportation, and recreation services each week. Companions also serve as role models for the children they work in social and daily living skills.

Families play an active role in the identification and selection of Classroom Companions, who are frequently recruited from within the student's extended family and community. Although no formal education is required, the ability to work effectively with children and a sensitivity for the special needs of children is vital. Once hired, Classroom Companions undergo training and orientation. According to the program's literature, particular emphasis is given to the supportive, facilitative, and non-clinical nature of the Companion role.

Services provided by Companions vary with the ages and individual needs of students but may include accompanying a student on the school bus, assisting a student with homework after school hours, assisting the student in classroom or other in-school activities, and participating in recreational/social activities with the student.

FUNDING

Participating agencies share the cost of the program, including salaries of Classroom Companions.

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Community Outreach Program for Education (COPE)

COMMUNITY OUTREACH PROGRAM FOR EDUCATION (COPE)

COPE combines an individualized educational/behavioral treatment plan with regular class integration and close communication with families.

OVERVIEW

The Community Outreach Program for Education (COPE) is a school-based program in Durham, North Carolina serving students in grades kindergarten through five who have emotional and behavioral disabilities and their families. The program's three components are the COPE classroom, mainstreaming, and work with families. COPE is jointly sponsored by the Durham County Schools Division of Exceptional Children's Services and the Durham County Community Mental Health Center, Division of Child and Youth Services.

PROGRAM/SERVICES

The COPE Classroom: The COPE program operates as a separate facility on the campus of an elementary school in Durham County. The COPE classroom is a highly structured educational environment which builds in consistent expectations of specified behaviors. Because of its low student-teacher ratio, the program is able to offer highly individualized academic instruction. The staff develops educational and treatment plans for each student. Students receive individualized academic instruction and participate in daily class activities regarding behavior, social skills, and problem solving. Counseling services are also available to students throughout the day.

The social skills model used by the COPE program serves as a framework for addressing social skills deficits and behavior problems in both regular and special education settings. The model includes Social Skills Group Rules, a Buddy Program/Social Skills Curriculum, Individual Self Help Skills, and Friendship Skills. The curriculum addresses behaviors often identified as interfering with a student's ability to progress in the educational environment and uses interventions that have proven effective in both reducing and preventing behavior problems.

Student placements at COPE average 9 to 12 months. In addition to the regular school-year program, COPE offers a half-day summer enrichment program which lasts for six weeks which focuses on academic, affective, and recreational activities.

Mainstreaming: When students are first placed in the COPE program, they spend the entire day in a COPE classroom. As students move up in the COPE reward system, they earn the right to become more involved as members of the regular classroom and are gradually re-integrated into their home-school classroom. Because mainstreaming can be challenging for COPE students, the program has built in supports.

An important component of this support is the Buddy System. According to program literature provided by COPE, before a student reenters the home-school classroom, the COPE program director and regular education teacher work together to select a peer buddy for the returning student. This relationship benefits the buddy pair in the areas of social skills and age appropriate developmental learning. The Buddy System helps the targeted student adjust to regular classroom expectations and enhances the leadership skills of the buddy.

The Buddy System provides significant benefits for reentering students. They receive immediate support and ongoing feedback on social and academic expectations in the classroom. The students have peer models for age-appropriate behavior and are encouraged to affiliate with a positive peer social group. The students also learn how to solve problems with assistance from their peer buddies.

The Buddy Program also benefits the peer buddy in that it provides an opportunity for growth in leadership and self esteem. The buddies learn how to provide behavioral support in the classroom and how to reinforce pro-social skills. Through regular group meetings the classroom buddies learn many skills essential to a meaningful helping relationship.

The Buddy Program helps educate of the community about at-risk students' needs and increases the acceptance of those children within the community. The program leads to better communication between the school and home as well as between the school and other agencies.

Work with the Family: The COPE program believes that cooperation between the school and family has a great impact on the student's performance at school. The aim of family involvement is to enhance and strengthen family life and problem solving skills. COPE staff members work to build a supportive and trusting relationship with the families of their students through frequent communication. Specific services provided to families include a parent support group, individual conferences, skill sharing, and referrals to community and private resources. According to literature provided by the COPE program, a student's progress, whether great or small, is noted, rewarded, and celebrated with their families.

Supplemental Services: The above direct services are supplemented by mental health support services, individual counseling, and clinical psychological consultation. Additionally, the program offers indirect services to individuals as well as to the community, including behavior management workshops and support and follow-up for former COPE students and their families.

STAFFING

The core COPE staff consists of a program director, family counselor, education specialists, classroom assistants, and a secretary. Additional support is provided by a consulting psychologist and consulting psychiatrist.

FUNDING

Operating expenses of the COPE Program are jointly shared by the Durham County Schools Division of Exceptional Children's Services and the Durham County Community Mental Health Center, Division of Child and Youth Services.

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A Comprehensive Community-Based Continuum of Care in Butte and Ventura Counties

A COMPREHENSIVE COMMUNITY-BASED CONTINUUM OF CARE IN BUTTE AND VENTURA COUNTIES

This project seeks to improve existing services in two California counties with emphasis on making the service system more culturally responsive and "family-friendly."

OVERVIEW

This project seeks to improve service delivery to students with emotional disabilities in Butte and Ventura Counties, California. Although both counties have innovative day treatment programs, an evaluation of those programs conducted during phase one of the project identified key areas for improvement. During phase two, system improvements are planned to move both counties toward a more comprehensive continuum of care. Three pilot sites—one elementary school in Butte County and two Head Start preschools in Ventura County—have been selected for participation. According to the project abstract, these sites "will model full-scale implementations of comprehensive, family-friendly, family-focused and culturally competent prevention and treatment services for families with children who are seriously emotionally disturbed, or who are at risk for developing serious emotional problems."

PHILOSOPHY

The project has developed a "Definition of Ideal Comprehensive Community-Based Continuum of Care" outlining its objectives which reads as follows:

1. Prevention, early identification

   A. Identifiable and clearly focused prevention services. Evidence of specific programs, mechanisms or procedures in the community and general education that build support for all students, including those who exhibit signs of emotional or behavioral difficulty.

   B. A System for early identification and intervention with students experiencing significant social and emotional problems. Mechanisms exist to assure that children who are exhibiting signs of emotional distress are identified early in their school career, and interventions initiated prior to a referral for special education services.

   C. Strong, collaborative, and culturally sensitive family and parent services in the community and regular education setting. Critical services include culturally sensitive and appropriately intensive family education, support, empowerment, crisis intervention, and treatment.

2. Ethnic, cultural, and community sensitivity in all areas of assessment and service delivery. Recognition that family needs and receptivity to services will vary based on key variables such as ethnicity, language, cultural differences, socioeconomic status, rural or urban nature of the community etc.

3. A clearly defined, comprehensive, and well integrated academic and treatment program

    A. A clearly articulated program definition that includes a description of the population served, eligibility criteria, treatment model including the major goals for students and families in the program, as well as the academic and treatment components that make up the program.

    B. An enriched and engaging academic program. Evidence that the academic program reflects the core curriculum in the surrounding educational community. Utilization of different grouping strategies, teaching techniques, materials and instructional strategies to create a richly textured learning environment.

    C. Comprehensive, multidisciplinary services and treatment options. Program utilizes (for example) academic, family, self-esteem, social skills, nutrition, medical, and behavioral management treatment options into a total program.

    D. Service elements are interconnected, integrated, and organized into a total program. Services are clearly linked and related to one another. for example, mental health services provided on-site, well integrated into the overall educational program.

    E. A range of placement options, from general education to residential treatment. A comprehensive and array of services, with effective transitions between more and less intensive levels of treatment.

    F. Clearly articulated case management responsibilities. Case management personnel are provided with the resources, authority, and training to effectively advocate for appropriate services for children and families. A model of case management is in evidence.

4. Flexible, developmental, growth and family oriented service delivery system

    A. Developmentally sensitive and appropriate services. Clear evidence that program planners and staff recognize that age and developmental status are critical variables in the development of interventions and development of staffing plans. Appropriate attention to individual differences in the learning styles and rates of students.

B. Health or growth oriented services. Evidence exists that the program recognizes that a primary goal of child and family focused services involves the promotion of healthy cognitive, scholastic, social and emotional development on the part of children and families, and not merely the remediation of pathology.

C. Flexibility in site and location of services. Evidence exists that genuine attempts are made to "wrap" services around the child and family in lieu of placing the child in a separate site-specific facility.

D. Flexible roles for service providers and parents. Evidence exists that teachers, case managers, and direct service personnel have enough expertise, supervision and autonomy to provide needed services that may go beyond their primary role as teacher, therapist, or case manager.

5. A strong and clearly defined interagency focus and coalition. Shared decision making and planning, with common goals developed between education, mental health, and other service providers. Political support from key decision makers in all relevant agencies.

6. Funding and financial support that is realistically adequate for program goals. An emphasis on the development of shared, coordinated, or blended funding streams whenever possible.

7. A commitment to staff development and training. Evidence exists of an organized and ongoing staff development program that is comprehensive, reasonably intensive, and makes use of cross disciplinary and collaborative training opportunities.

PROGRAM/SERVICES

During phase one, researchers in the California SED Work Group conducted a careful analysis of the key features of the existing programs in both counties, comparing these to the definition of an ideal comprehensive community-based continuum of care described above. Using that definition to analyze the Butte and Ventura County programs, researchers identified the following six areas where the programs fell short of the ideal and needed improvement.

- Cultural competence: Neither county is identifying or serving students from diverse ethnic and cultural communities, and outreach efforts to under-served populations are not apparent.

- Family friendly: Parents and providers describe their relationship as adversarial; more family involvement and genuine collaboration with families is needed.

- Prevention and early intervention: Neither county has developed a systematic program for screening and early identification for children at risk of developing serious social and emotional problems.

- Eligibility: Eligibility decisions based on federal definitions exclude many students; viable educational and treatment alternatives need to be created.

- Collaborative family-centered treatment: A team approach to working together with common goals and understandings is needed.

- Monitoring student progress: Monitoring student progress varies considerably within the counties and is virtually non-existent once students are no longer receiving treatment. Evaluation based on student outcomes needs to be instituted in a systematic fashion.

During phase two of the project, a reorganized service continuum will be implemented at pilot sites. Improvements to existing programs will include 1) implementation of a full scale model of prevention, early intervention and treatment, including systematic screening to detect early warning signs of emotional disabilities; 2) training of case managers for cultural, environmental, racial, religious, and sexual orientation sensitivity in assessment and service delivery; 3) a commitment to staff development and training; 4) an emphasis on nurturing and empowering families; 5) involvement of parents as "true partners" in problem identification, treatment planning, and outcomes evaluation; 6) implementation of a multi-faceted and comprehensive evaluation component for all students; and 7) increased interagency coordination.

Project coordinators believe that development of a "culturally responsive and family-friendly system will divert children and families from needing expensive categorical services by intervening before their needs overwhelm their adaptive functioning and challenge the ability of the system to react," according to information provided by the project. Implementation of phase two will alter the existing system of care by targeting younger children and families who are at risk. Project coordinators also believe that the systemic barriers to effective service delivery they have identified are representative of those that need to be addressed in other communities nationwide. Thus, the experiences and outcomes of phase two implementation will be of interest to other communities with similar needs interested in improving their systems of care through replication of this model.

EVALUATION

A combination of short-term, long-term, and family outcome indicators are planned to evaluate the effectiveness of this continuum of care for students and their families.

FUNDING

Phase one of this project was funded by a U. S. Department of Education grant with additional funding from the California Department of Education, Special Education Division. Phase two will continue with state support.

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Connections Initiative

are spent for contracted services. Additionally, PEPTRACK is used to evaluate client progress and achievement of objectives.

FUNDING

Connections uses flexible, integrated funding of participating child service systems. This blended approach eliminates cross-system service barriers and allows Connections to finance flexible services that match individual child and family needs. Services are purchased from local providers, with emphasis on case management, day treatment, and home-based services.

Connections uses a prepaid capitation model for reimbursable Medicaid services for children and youth served who are Medicaid-eligible. Connections is also one of eight sites across the country selected to receive funding through the Robert Wood Johnson Foundation's Mental Health Services Program for Youth.

EVALUATION

The Connections Initiative "has been the driving force behind many new initiatives and consortia throughout the country," according to literature provided by the project. The Robert Wood Johnson Foundation describes the project as "an example of a major collaborative effort that has made a difference in the lives of children and their families, and where crucial barriers are being overcome" (Cole & Poe, 1993, p. 39).

ADDITIONAL INFORMATION

A profile of the project is included in *Partnerships for Care: Systems of Care for Children with Serious Emotional Disturbances and Their Families.*

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PROGRAM/SERVICES

The Connections project provides mental health case management and facilitates needed services for youth through the use of home and community based services. Case managers help families navigate complex service systems, link families to neighborhood based resources and social supports, and purchase mental health services. Connections believes that the more involved parents are in their children's plans, the better those plans will be. Thus, parents serve as members of the service planning team.

School-based Services: Connections believes that building partnerships with schools offers the best opportunity to bring about long-term, positive change. Case managers "go where the kids are" to offer individualized care at school. Because about half of the students change schools during the year, case managers follow students to nearly 80 schools in the Cleveland area. Case managers become members of the school's "extended staff." Using this school-based model places an emphasis on the school as an "agent of change." Case managers working in the school system increase the awareness and sensitivity of educators toward mental health issues. "By working side-by-side with teachers in the schools, case managers forge partnerships that help teachers know that they are not alone when working with very difficult, troubled young people" (Smith, 1992, p. 8). With this cooperative approach at work, parents come to view schools as allies, rather than merely educational institutions.

Non-school-Based Services: Services offered by Connections outside of school settings include a mobile crisis team available to case managers 24 hours a day; a family aide service in which trained parents of emotionally disturbed students are hired to support case managers and families; a mentoring program to help youth learn social integration skills; intensive in-home services for family preservation; therapeutic foster care as a form of residential placement delivered within a family-based environment; and in-home and out-of-home respite to provide structured relief designed to enhance and maintain family stability.

Through the Homeward Bound/Independent Living Program, older adolescents are assisted in their transition from institutional to community-based living. An intersystem treatment team helps provide the supports and linkages to the adult community to help adolescents make the transition from dependent children to self-sufficient adults.

Case Management: Connections uses the PEPTRACK case management information system, which provides current and historical client information. It can provide statistical information of the client population by category as well as more general aggregate information for the entire population. The PEPTRACK data records a youth's placement, history, service providers, legal guardianship, educational placements, and other information. The system can also be used to track how funds

CONNECTIONS INITIATIVE

This school-based model of mental health services emphasizes schools as "agents of change."

OVERVIEW

The Connections Initiative in Cleveland, Ohio has developed a coordinated service delivery system to effectively support children and youth under 18 years of age who have emotional disabilities. In the past, according to literature provided by the project, "no one system has been able to adequately serve their needs, and many of these children and their families have often slipped through the cracks and received no help at all." The project has sought to eliminate unnecessary gaps and duplication in Cleveland's child service systems and to create a common plan for each child and family. The program works with existing service systems in the community to coordinate the treatment, planning, funding, delivery of culturally sensitive services, and development of innovative services to meet the individual needs of these youth and their families.

Project partners include the Cuyahoga County Community Mental Health Board, the county Board of Mental Retardation/Developmental Disabilities, the county Alcohol and Drug Addiction Services Board, the Ohio Department of Youth Services, the county Juvenile Court, Cleveland and East Cleveland Public Schools, and the county Department of Children and Family Services. The project is administered by the Positive Education Program (PEP).

PHILOSOPHY

Connections believes that just as no two individuals are alike, no two service plans are necessarily alike either. The project seeks to provide home, school, and community-based services to prevent out-of-home placement and return youth who have been placed out of the home. The goal of the project is to eventually wean clients from the need for formal mental health services through a "systematic integration of natural community supports." The program embraces the belief that "children need to be brought to a level where they can speak for themselves, and have relationships built on capacity, rather than deficiency."

Connections has adopted the concept of wraparound services for the youth served by the program. Wraparound money can be used for non-traditional mental health services, programs, or other expenditures identified as necessary to meet treatment goals. These services may include transportation, mentoring, club memberships, art or music lessons, recreational activities, homemaker services, home health aides, and respite services.

Empowering Families & Schools

Empowering
Families & Schools

EMPOWERING FAMILIES AND SCHOOLS

The project seeks to empower parents to actively participate in their children's education and treatment for emotional and behavioral disorders.

OVERVIEW

This project seeks to develop strategies to reduce out-of-community residential placements and encourage the use of school-based programs to meet the needs of youth with serious emotional disturbance. The project is forming an alliance with parents designed to promote collective responsibility and support for families with youth who have been identified as seriously emotionally disturbed. Operating at three school sites in the Albuquerque School System, the project's importance lies in the fact that it: a) addresses the needs of minorities; b) tests strategies for dealing with youth with serious emotional disturbance; c) helps formalize the linkages between schools, families, and service providers in the community; d) empowers parents to become an active and knowledgeable part of the treatment process; and e) tests the conceptual construct of having all caregivers and community resources use a clinical strategy tailored to the individual needs of each youth.

In order to encourage families to take a more integral part in these programs, the project has three family-oriented components: a) the Alliance of Parents Council, 2) An Experiential Program, and 3) a Home-based Social Worker Project.

PHILOSOPHY

This project is based on the philosophy that "parents and family are key to successfully serving children and youth in the community. To succeed, parents and families must be empowered to work with schools and agencies to better meet the needs of the individual student. By linking family support services to school services, families will be empowered to more actively participate in their children's education."

PROGRAM/SERVICES

The project serves 90 targeted students ages 11 to 18 at three school sites, who have been identified as seriously emotionally disturbed and whose needs are not being met by other district programs. Services to youth and families participating in the project are based upon three components--the Alliance of Parents Council, the Home-based Social Worker Project, and the Experiential Program.

A multidisciplinary team has been designated at each of the three sites. Each team consists of a psychologist, a social worker, special education teachers, and a site administrator. These teams help select members of the Alliance of Parents Council, identify families to receive home-based services, and identify families for participation in the Experiential Project.

The Alliance of Parents Council is designed to involve parents in their child's program in ways that are positive and empowering. An Alliance of Parents Council has been established at each of the three school sites. Each council serves as a vehicle for parents to advise staff and agencies on the effectiveness of behavior management strategies, curricula, and policies. Council members also form support groups and encourage other parents to participate in a variety of school activities. Parents serving on the council are paid a stipend to attend monthly two-hour meetings. Transportation to meetings is provided by the outreach worker, if needed. A newsletter disseminates information on the activities of the council.

The second program component--the Home-based Social Worker Component--provides specialized case management to families based on plans developed with family members. Two full-time social workers work with the multidisciplinary teams at each site to identify ten families in most need of services. These social workers must be competent and sensitive to the cultural and social values of the families served. A small caseload of five families for each social worker allows for intense involvement. Each social worker makes a minimum of three visits to each family per week, offering individual and family therapy as needed, and are available for crisis intervention/prevention after hours and through the summer months. Social workers seek to establish a close relationship with the families and work with them to secure appropriate services for their children, improve their parenting skills, and connect them with school programs in a positive way. The social worker communicates with school personnel and families on a daily basis. This constant flow of information is designed to improve school and family relationships.

The Experiential Program is also designed to strengthen another connection between schools and families. The focus of this program is to build trust, self-reliance, and responsibility and to create a more positive relationship among all participants. The experience includes a basic ropes program and a more difficult high ropes course designed to teach problem solving, self-sufficiency, and cooperation. The final phase of the Experiential Program is a three-day wilderness trip in which the families and students chosen to participate learn basic survival skills and are challenged to overcome fear, develop self-efficacy, and relate to each other as equals as they solve mutual problems.

FUNDING

The Empowering Families and Schools project is funded through a U. S. Department of Education grant from November of 1993 to October of 1995.

EVALUATION

Evaluation activities are ongoing as well as retrospective. Assessments used by the project include student attendance records, student academic progress reports, pre/post assessments of family dynamics and relationships, social worker anecdotal records, parent interviews, agency interviews, school staff interviews, numbers of students staying in high school programs, and numbers of students placed in hospitals, residential treatment facilities, and juvenile correctional facilities. Video-taping and behavior charting are methods being used to evaluate effectiveness of the project.

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Facilitating Integrated Interagency Services for Seriously Emotionally Disturbed Children in Nashua, NH

Facilitating
Integrated
Interagency
Services for S. E. D.

FACILITATING INTEGRATED INTERAGENCY SERVICES FOR SERIOUSLY EMOTIONALLY DISTURBED CHILDREN IN NASHUA, NH

This project has filled a void in the community by offering students opportunities to participate in recreational programs after school and during the summer months.

OVERVIEW

The Facilitating Integrated Interagency Services for Seriously Emotionally Disturbed Children in Nashua, New Hampshire is a project created to develop an array of services for students with emotional and behavioral disorders, including after-school recreational services and summer programming. These services are intended to provide a continuum of care for youth and their families to enable participants to function more appropriately in school, at home, and in the community. The federally-funded project is a collaborative effort of the Nashua Public Schools, the Community Council, the Youth Council, the Adult Learning Center, and the YWCA of Nashua, New Hampshire.

Goals of the project include:

- Increasing interagency collaboration among educational, community mental health, and recreational facilities in the treatment and case management of children and adolescents with emotional/behavioral disabilities;
- Increasing the availability, quality, and ease of access to community mental health for children and adolescents with emotional/behavioral disabilities and their families, particularly those from inner city, disadvantaged, and minority backgrounds;
- Increasing the availability, quality, and ease of access to recreational services for children and adolescents with emotional/behavioral disabilities and their families, particularly those from inner city, disadvantaged, and minority backgrounds, and thereby improving their self-esteem, their internal locus of control, and their behavior; and
- Improving the problem solving skills, parenting skills, and networking ability of parents of children with emotional/behavioral disabilities through interagency parent support group and family therapy participation.

PROGRAM/SERVICES

The Nashua project strives to increase interagency collaboration among educational, community mental health, and recreational facilities in the treatment and case management of students with emotional/behavior disabilities. A core team with representation from all of these agencies holds regular "wraparound" meetings to discuss the case management of students and their families participating in the project.

Collaboration between schools, mental health agencies, and recreational agencies in Nashua has resulted in the development of parent support groups, family therapy services, training and support groups for teachers and school and recreational staff members who work with students with emotional/behavioral disabilities, and recreational activities for students after school and during the summer months.

Parent support groups meet in local schools during early evening hours; child care, food, and transportation are provided. These groups are co-led by a school psychologist and a community mental health therapist in a familiar, informal atmosphere.

Family therapy services are also provided during the early evening in neighborhood schools and settings familiar to parents. Childcare and refreshments are provided. These groups are also co-led by a school psychologist and a community mental health therapist. The primary goals of this multiple family group therapy approach are to improve family communication, improve the understanding of family dynamics, and change behavior within the family.

The Nashua project has increased the availability, quality, and ease of access to recreational services for children and adolescents, particularly those who live in disadvantaged, inner city areas. Transportation is provided to after-school recreational programs which expose students to a wide variety of activity-based experiences, including improvisational theater, swimming, tennis, dance, karate, and therapeutic horsemanship. A psychologist accompanies students to recreational programs and provides feedback on student interactions and behavior. The project also provides funding to hire and train auxiliary staff members working in these recreational programs.

EVALUATION

An outcome-oriented evaluation plan for the project focuses on the benefits to individual students and their families. The program will be evaluated by demographic information, the functioning of students who participate in the after-school, summer, and family therapy programs, parent satisfaction with the program, and staff satisfaction.

A 1993 project review revealed that interagency collaboration, with wraparound interagency meetings and staff training, has been highly successful. Parent support groups have been successfully implemented, although more outreach is needed. Recreational services have been in high demand and successful. School psychologists have played varied roles in implementing all aspects of the project and have been critical to its success.

FUNDING

The project was funded by a U. S. Department of Education grant for an 18-month period ending June 30, 1994. Certain facets of the program are continuing through the support of local efforts.

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Family Mosaic Project

FAMILY MOSAIC PROJECT

Family Mosaic has built a team of caseworkers called Family Advocates whose ethnic and cultural mixture reflects the diverse composition of the population they serve.

OVERVIEW

The Family Mosaic Project is an interagency effort to provide a coordinated system of care for children and youth ages 3 to 18 with emotional disabilities and their families who live in the San Francisco area. The goal of the project is to enable these children and youth to continue to live at home or in the local community while receiving treatment, education, and support. Family Mosaic has brought together resources from public health, mental health, social services, juvenile justice, and education to build a collaborative program that includes interagency participation in planning, treatment, and funding. "By developing a neighborhood-based system of care that is designed for a high degree of cultural competence and community cohesion, Family Mosaic has laid the foundation for rapid replication and city-wide implementation" (Cole & Poe, 1993, p. 18).

The project is a joint effort of the San Francisco Department of Public Health, Community Mental Health, Department of Social Services, San Francisco Unified School District, and Juvenile Probation. The project is administered by the San Francisco Department of Public Health, with funding provided by the State Department of Mental Health and the Robert Wood Johnson Foundation. The Family Mosaic Project's Interagency Advisory Committee encompasses broad representation, including mental health, education, juvenile justice, civil rights and parent-child advocacy groups, parent organizations, and other community-based groups, which oversee progress of the project.

Family Mosaic is approaching system reforms on three levels—with families, with service providers, and through financing systems. According to literature provided by the project, Family Mosaic "places a high priority on working in partnership with families with an emphasis on addressing the unique characteristics of San Francisco's diverse cultural communities. Cultural competence is a guiding principle that is used to design and evaluate service delivery, staffing composition, training approaches and priorities, community involvement and technical assistance. A health and human services perspective is in place to ensure that the needs of the whole child within the context of his/her family are addressed in a comprehensive and consistent approach."

PROGRAM/SERVICES

To begin services, project caseworkers called Family Advocates gather information about the child or youth and services the family is currently receiving. Following a clinical case conference, the family and relevant service providers meet in a plan of care meeting to determine needs for specific services and ongoing case management. Family Advocates facilitate the purchase of services specified in the care plan.

The project has developed intensive community support services that bring professional help into the home, classrooms, and community settings. An array of services are provided, including early intervention counseling services for at-risk students through the Primary Intervention Project, tutoring, mentoring, day treatment, in-home parenting education, parent training, family therapy, crisis services, respite care, therapeutic foster care, therapeutic group care, substance abuse services, therapeutic camp experiences, independent living services, and inpatient and outpatient care.

Family Mosaic has developed a comprehensive training program for staff members, providers, and parents. The project has also encouraged the development of parent advocacy and parent support activities.

STAFFING

Family Mosaic has built a team of caseworkers called Family Advocates whose ethnic and cultural mixture reflects the diverse composition of the population they serve. These advocates represent multiple human services agencies, including mental health, juvenile justice, child welfare, public health, and education, but work together under one roof. Using a team/multidimensional case management model, the project combines two Family Advocates with three social workers called Family Workers who share case management responsibilities for 40 to 50 families served. Team members meet during weekly clinical case conferences led by a medical director and clinical psychologist. The project also benefits from local graduate psychology and social work interns and psychiatric and pediatric residents who serve Family Mosaic in varying capacities.

FUNDING

In 1993 Family Mosaic began piloting a capitation-financed system of care with the California Department of Health and Welfare to provide more flexible services; the project has also initiated mini-capitation arrangements with community-based mental health agencies to provide culturally sensitive services for targeted populations. The project has also expanded Medicaid reimbursement through targeted case management. Additional dollars of support are pooled from county-level categorical programs such as child welfare, education, and juvenile justice in order to maximize federal financing, particularly through Medicaid and Title IV-E. The project also relies upon federal block grant money.

EVALUATION

The program's development of community-based services has reduced the need for inpatient care, residential care, and crisis services. Improved school attendance and school performance coupled with a decrease in detention days among students served by the program are also indicative of initial successes of this project (Cole & Poe, 1993).

ADDITIONAL INFORMATION

A profile of the project is included in *Partnerships for Care: Systems of Care for Children with Serious Emotional Disturbances and Their Families.*

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Georgia Psychoeducational Network

GEORGIA PSYCHOEDUCATIONAL NETWORK

The Georgia Psychoeducational Network brings psychoeducational services to within 30 minutes of every child in the state.

OVERVIEW

The Georgia Psychoeducational Network provides comprehensive special education services for children and youth ages birth through 21 years with emotional disturbances or autism. The Network, part of the public school continuum of services, is comprised of 24 regional, multidistrict day programs that offer cost effective alternatives to residential care. The network is distinctive in the following ways:

- It offers comprehensive services: Each youth referred to a psychoeducational center may receive a full range of services, including diagnosis, treatment, periodic evaluation, and follow-up;
- It is a cooperative effort of education and mental health;
- It is community-based and family-centered;
- It offers assistance to parents and regular school teachers who need guidance;
- It reaches geographically distant counties, bringing psychoeducational services to within 30 minutes of any child in the state; and
- It shows successes documented by a network-wide evaluation system. (Wood, 1977)

PROGRAM/SERVICES

Services are provided with the belief that students can be maintained in their communities with a specialized psychoeducational program that focuses on treatment. The educational program includes a Preschool Program for children ages birth through five years, a Children's Program for students ages 6 to 14, and an Adolescent Program for students ages 15 to 21. A team of supervisors, coordinators, school psychologists, teachers, and paraprofessionals work together to provide appropriate educational services. For secondary students, the Adolescent Program emphasizes the development of academic, behavioral, and emotional skills to help prepare students for transition to independent living.

Support services such as assessment, psychological and/or psychiatric consultation, and family services are provided by a support team of social workers, psychologists, consulting clinical psychiatrists, and infant evaluators.

The Rutland Developmental Therapy Model: Several programs that are a part of the network, particularly those serving preschool and elementary-aged children, use the Rutland Developmental Therapy Model, which is validated for replication by the

National Diffusion Network. The Rutland Center became the prototype from which the psychoeducational network was developed in 1970. The model that bears its name is a psychoeducational approach to therapeutic intervention with children, especially appropriate for ages two through eight. Based on the assumption that children with disabilities go through the same stages of development their peers do, but at a different pace, the curriculum is a "growth model" rather than a "deficit model" that uses normal developmental milestones to guide the therapeutic process. The Developmental Therapy curriculum includes four areas. These areas and the messages they convey to children are:

- behavior— "Appropriate behavior is important."
- communication— "It helps to talk about things."
- socialization— "The group is important."
- academics or pre-academics— "This is school work you can handle." (Wood, 1977, p. 9)

Within each curriculum area are five "maturational sequences" which cut across all areas. These sequences are 1) responding to the environment with pleasure, 2) responding to the environment with success, 3) learning skills for group participation, 4) investing in group processes, and 5) applying individual and group skills to new situations. Developmental therapy incorporates clinical inference, teacher judgment, and behavioral measurement in the same model so that the evaluation system becomes a part of the therapeutic process (Wood, 1977, p. 9). The therapeutic curriculum can be used in special classroom settings with small groups of students or in integrated classroom settings. The mainstreaming aspect of the model requires that regular school experiences mesh smoothly with intensive Developmental Therapy experiences. Special services to parents and parent involvement are also considered an integral part of the approach.

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Iowa City Collaborative Integration Project

Iowa City
Collaborative
Integration Project

IOWA CITY COLLABORATIVE INTEGRATION PROJECT

An automated 'early warning system' 'flags' potential children who are at risk for developing emotional disabilities.

OVERVIEW

The Iowa City Collaborative Integration Project addresses policy, program design, and technical issues involved in service system changes for students with emotional disabilities. It is a collaborative project of the University of Iowa Hospitals and Clinics, Mid-Eastern Iowa Community Mental Health Center, Iowa Department of Human Services, Grant Wood Area Education Agency, Iowa City Community School District, and the parents of children with emotional disabilities.

The project aims to break down barriers between service agencies who work with youth with emotional disabilities in kindergarten through sixth grade to enhance networking and cooperation. It seeks to build a system to facilitate "collective client pathways" which integrate services through the development of a single treatment plan used by all service agencies in which each has a specified role. Additionally, the project seeks to "intervene as early as possible, integrate services, improve program effectiveness, avoid duplication, and maximize the use of existing community resources." It primarily targets resources to the school setting.

The first phase of the project involved piloting the program at two elementary schools, one supported by private funding and the other supported by a federal grant. Expansion of the project into more of the district's 16 schools will continue, the rate dependent upon current funding sources.

Several unique features of the project are highlighted in the project abstract:

- The focus is on the earliest possible intervention with children and their families;
- An automated "early warning system" "flags" potential children who are at risk for emotional disabilities;
- Parents are empowered to participate actively in the treatment process by serving as their own case managers; and
- The schools and local mental health agencies integrate their services and work together as partners to develop case plans, make referrals, and jointly monitor service.

The project is overseen by a policy council comprised of representatives from participating agencies and parents of children with emotional disabilities. The council assists project staff with networking and collaboration strategies designed to identify barriers in federal and state laws and regulations that may prevent outcomes from being achieved.

PROGRAM/SERVICES

Through the automation of data available to staff, children who might qualify for services are identified by the early warning system. Participating schools compile predictive information for identification of students who may be at risk for emotional disabilities. The early warning system developed for the project scans the computerized data on a monthly basis to "flag" potential students. Once these children are identified, they are referred to the multi-agency intervention team.

Identified youth and their families then become part of the multi-agency intervention team which plans and monitors the service plan according to changing needs of the youth and family. After completing the required training, the parent of the child becomes the case manager of the team.

The project has developed a Behavior Disability Curriculum which includes beliefs and policies, outcomes, strategies for behavior management and affective education, and suspension/expulsion procedures. Portions of the curriculum are included in Appendix D.

FUNDING

The Iowa City Collaborative Integration Project is funded through private sources, district support, and a federal grant from the U. S. Department of Education, which began in October of 1992 and continues through September of 1996, provided subsequent phases of the project are refunded.

EVALUATION

This project seeks to test the assertion that "an intervention program that 1) empowers parents to take control of their child's development, 2) is culturally sensitive, and 3) integrates community services within a school building will be more successful than the current system of treating children and families."

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Kaleidoscope

KALEIDOSCOPE

Kaleidoscope operates on the premise of unconditional care where no one in need of care is turned down or turned away.

OVERVIEW

Kaleidoscope, Inc. is a licensed, not-for-profit child welfare agency located in Chicago, Illinois that has served children and youth considered to be among the state's "most-in-need" for more than two decades. Based on the premise of "unconditional care" where no one is turned down or turned away, Kaleidoscope's service philosophy asserts that children "need loving care regardless of their behavior, and rejecting them from care for misbehavior worsens their condition and our society's burden." This philosophy assumes that when problems arise it is the role of the service provider to change the structure of the service rather than reject youth from services. In treating troubled youth humanely and effectively, Kaleidoscope also ascribes to the concept of normalization —that children learn best living and learning in a normal environment—meaning a family or family-like environment, neighborhood, or community, instead of living in an institution or residential center with others who have similar disabilities.

PHILOSOPHY

According to literature provided by Kaleidoscope, key principles of the project's programs and services are based on the following:

- To accept into care those children who have been in or are bound for institutions;
- To serve children regardless of the severity of their behavioral problems or emotional disorders;
- To provide family services to prevent out-of-home placements or to reunite children who have been placed outside of their homes with their families. When children must be removed from their own families, Kaleidoscope provides them with substitute care in foster families and the agency itself becomes an "extended family" to the children and youth served;
- To believe that caregivers—parents; child care workers, and foster parents—are the most important treatment resource for children, providing role models and loving parental care;
- To help children, youth, and their families be self-sufficient and live as normally as possible. For younger children, this means giving them the

security of a stable family life and ensuring they receive a good education. For other youth, major service goals include acquiring job skills, independent living skills, and ensuring there are people in their lives who are "family;" and

- To advocate for better policies and programs for children who are considered to be most in need.

This philosophy of service is based upon the concept of wraparound interventions for troubled children and youth. A wraparound intervention is one that is developed and/or approved by an inter-disciplinary services team, is community based and unconditional, is centered on the strengths of the youth and his family, is culturally competent, and includes the delivery of coordinated, highly individualized services in three or more life domain areas (residential, family or surrogate family, social, educational or vocational, medical, psychological/emotional, legal, and safety) of a youth and his family. A more detailed explanation of the wraparound concept is described in Appendix E.

PROGRAM/SERVICES

Kaleidoscope, Inc. operates three programs for children and youth and a training institute. Each is described here:

Satellite Family Outreach Program: This program provides intensive services to families so that youth with emotional disabilities placed in residential settings can be returned home safely and so that those not in residential placement have a better chance to remain in their own homes. Satellite families receive 80 - 125 hours of service support per month, most of them provided in the home. Services include help with basic needs —food, housing, recreation, child and home management—as well as counseling and therapy. Staff members also act as liaisons with other community services, including the public school system. A more detailed description of the program and services offered is described in Appendix E.

Therapeutic Foster Family Program: This program provides family living and specialized services to youth, including those with emotional disabilities, who otherwise would be placed in institutions, . The major goal of the program is to provide unconditional care for the youth served—to keep them in family settings regardless of the difficulty of their behavior or needs. Unlike most foster family care, Therapeutic Foster Family homes are not just places for youth to live temporarily until they can go back home. Most of these youth will not return to their biological families because their parents are unable to meet their basic needs; they will either stay in foster case or enter the Youth Development Program and learn the skills to live independently. Foster care professionals provide specialized care so that individuals can stabilize their behavior, stay out of institutions, learn to live in families, and, if they are adolescent parents themselves, learn effective parenting skills.

Additional goals of the program are to promote self-respect and maturity by building self-esteem, to provide structure and limits to encourage responsibility and control, to help resolve trauma from loss and separation, to provide role models, and to teach alternatives to misbehavior. The program uses a team approach to carry out individualized treatment plans. Among the collateral services provided by the program are connections with schools and other educational resources. A more detailed description of the program and services offered is offered in Appendix E.

Youth Development Program: This program helps older, severely troubled adolescents learn to live on their own. Adolescents served in this program cannot live with their biological families, yet they are too old to be adopted. Many have severe emotional/behavior problems and have not made progress in other program placements.

The Youth Development Program staff helps young people to live independently in apartments, take care of themselves, monitor their own behavior, build supportive ties with friends and family, and find and retain jobs. The agency also arranges for medical care, therapeutic recreation, and individual and group therapy. Service goals common for all youth in the program are to help them stabilize their behavior, teach them to live independently in the community, help them become self-supporting to the maximum extent possible, and keep them out of institutions. Collateral services offered by the staff include connections with schools and educational resources. A more detailed description of the program and services offered is described in Appendix E.

Training Institute: Kaleidoscope has initiated a training institute that provides consultation, training, and day-to-day "know how" of program implementation. The institute grew in response to requests for additional, in-depth training, and a desire of the agency to share 19 years of experience and lessons learned serving emotionally disabled youths. Services offered through the training institute include: consultation, on-site training, needs assessment, technical assistance, conference workshops and keynote addresses, and in-depth workshops and training at the institute.

ADDITIONAL INFORMATION

A more detailed description of Kaleidoscope services is offered in Appendix E.

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Kentucky Bluegrass IMPACT

KENTUCKY BLUEGRASS IMPACT

Kentucky Bluegrass Impact seeks to develop a full continuum of community and family-based resources as a demonstration of a system of care that can be replicated in other regions.

OVERVIEW

Kentucky IMPACT (Interagency Mobilization for Progress in Adolescents' and Children's Treatment) helps to create and coordinate services for children and youth with emotional disabilities that allow them to receive care at home or in their community. IMPACT coordinates services among Kentucky's five child-serving systems: education, health, social services, mental health, and the courts. IMPACT's multisystem cooperation brings families and agencies together to decide what is best for each child.

Kentucky IMPACT grew out a regional project called Bluegrass IMPACT funded in 1989 by a Robert Wood Johnson Foundation grant to serve 17 counties. One year after Bluegrass IMPACT was planned, the Kentucky legislature authorized $19 million to replicate the IMPACT service and funding model statewide. Under this legislation, state funds were allocated to three state departments already serving youth with emotional disabilities—Mental Health and Mental Retardation, Social Services, and Medicaid Services—and then distributed to Kentucky's 18 regions. The initial legislation established a structure for coordinated policy development, comprehensive planning, and collaborative budgeting for services for children and youth with emotional disabilities and their families. Further, the legislation was intended to build on existing resources to design and implement a coordinated service system for youth with emotional disabilities that was community based and centered on the needs of the individual and the family.

Each region of the state is striving to build a continuum of services ranging from the least restrictive service of community-based treatment to more restrictive options, based on the premise that "sometimes the best medicine is a home remedy. Especially if it means keeping a child with a severe emotional disability out of a psychiatric hospital or other treatment facility. Although some children do require hospitalization, most children have a better chance of doing their best when they receive care at or near their home, surrounded by a loving family and a supportive community" (Changes for Children, 1993, p. ii).

Prior to IMPACT, the state had no way to pay for nontraditional services, and children were either hospitalized or received outpatient services that were inadequate, according to Kentucky Department of Mental Health Director Ed Maxwell. "IMPACT gives us an enormous amount of flexibility and guarantees we can obtain just exactly what the child needs," says Maxwell ("Kentucky Impact: A Close-up," 1993, p. 1).

The goals of Kentucky IMPACT include:

1) To increase social competence and reduce behavior problems among children with severe emotional disabilities;
2) To help children live in the least restrictive setting possible;
3) To reduce the number of places a child lives during a year;
4) To increase the support to families of children with severe emotional disabilities;
5) To develop a program that works for the children and families who receive services; and
6) To develop a new way of serving children with severe emotional disabilities and their families that is more cost-effective.
(*Changes for Children*, 1993, pp. 6 - 9)

Overall administration of Kentucky IMPACT is provided by the State Interagency Council (SIAC) composed of state-level administrators and one parent, who develop interagency policies, coordinate tracking of clients, and insure full services in each region. The state's 120 counties are served by 18 Regional Interagency Councils (RIACs) that coordinate funding, interagency collaboration, and service plans. Each of the four child-serving agencies as well as parents have representation on the Council. Each region decides how to spend its allotted resources based on individual needs of the youth served and community resources. The SIAC oversees activities of the regional councils and provides them with technical assistance.

The State Interagency Council, created by this legislation, has statutory authority over policy issues statewide, and each of the state's 15 regions has at least one Regional Interagency Council. The RIACs oversee interagency collaboration among local service systems, review nominations for entry into IMPACT, authorize budgets and individual service plans, and hear appeals.

PROGRAM/SERVICES

Each youth's Service Team brings together parents, service professions, community members, and the youth (when appropriate) to discuss the youth's strengths and challenges and design an appropriate service plan. Service coordinators act as case managers who coordinate a variety of social, medical, educational, vocational, residential, and other services determined by the plan. Service coordinators monitor the progress of the service plan and convene team meetings on a regular basis.

Services coordinated through IMPACT may include school support services, flexible response services, recreational therapy, wraparound services, therapeutic foster care, summer programs, and parent advocacy. Direct services provided by IMPACT staff include home and school therapy, parent training, home management and transportation assistance, respite care, recreation and leisure activities, therapeutic camping, and school and community consultation.

For youth at risk for relapse and rehospitalization or repeated use of emergency interventions, more intensive services are provided. An individualized package of supportive resources is "wrapped around" each youth and his family to help the youth live successfully at home and in the community. Examples of these services include crisis intervention and support, specialized evaluations, respite care, transportation, in-home attendants, specialized tutoring, and specialized skill development such as behavioral management.

Because IMPACT involves the state's most challenging children and involves multiple agencies at the state, regional, and local levels, training has been one of Kentucky's primary strategies. The state's training agenda includes agencies, parents, and local providers, and is supported by the legislated design of the interagency structure and by the process for credentialing service providers. In addition to regular training sessions, the project holds Training for Trainers workshops twice yearly to provide trainers with the skills needed to conduct IMPACT's various training programs. Additionally, a 28-minute orientation video and a reference manual detailing the collaboration process have been developed.

FUNDING

IMPACT has aggressively utilized Kentucky Medicaid dollars through the rehabilitation option to fund expanding services for youth, including targeted case management, intensive in-home services, and other intensive services that can be provided at home and in school settings. Additional state dollars provide support to the Regional Interagency Councils for staffing. Flexible dollars are administered regionally to ensure interagency collaboration of all responsible agencies serving individual youths and their families.

EVALUATION

According to a two-year evaluation report (*Changes for Children*, 1993), Kentucky IMPACT has made progress toward all of its six goals. Evaluation data shows a greater use of community resources and less reliance on psychiatric hospitals as well as a reduction in multiple placements. Additionally, placement cost savings have totaled $4 million during the first two years of the project. Outcome studies show a higher level of satisfaction with IMPACT services among youth, families, and teachers than with traditional service systems.

ADDITIONAL INFORMATION

A profile of the Bluegrass Impact project is included in *Partnerships for Care: Systems of Care for Children with Serious Emotional Disturbances and Their Families.*

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Linn County Youth Service Teams

Linn County Youth
Service Teams

LINN COUNTY YOUTH SERVICE TEAMS

Each Youth Service Team develops its own specific processes and procedures and reflects the needs of the region it services.

OVERVIEW

Youth Services Teams provide interagency collaboration between schools, social service agencies, law enforcement agencies, and other community resources in Linn County, Oregon. The purpose of these teams is to enhance the quality of services to youth and their families and promote communication.

The Youth Services Teams are part of the Linn County Project, a federally funded project in phase two of implementation, which seeks to:

- Develop a comprehensive array of services
- Establish an interagency collaborative process for developing a comprehensive Individualized Family Service Plan for each child with serious emotional disturbance
- Design a process for screening identification and early intervention
- Design a mechanism for service plan coordination and modification
- Institute a financing plan to support implementation of the service delivery design

Four components provide the framework for designing, implementing, and evaluating the project's comprehensive model: 1) Project Advisory Board, 2) Youth Service Team, 3) Case Management Services, and 4) Continuum of Services for Managing Student Behavior.

The Project Advisory Board, which includes a parent, child advocate, mental health consumer, and education representative as well as representatives from each child and family service agency in Linn County, oversees the project. The board is responsible for drafting policies, developing interagency agreements, and setting standards for developing a comprehensive plan for youth with emotional disabilities.

The project uses the Youth Service Team process as the avenue for interagency collaboration to develop a comprehensive individualized plan which incorporates social and educational support for students with serious emotional disturbance and their families. A school representative, parents, and case manager provide the linkage between the plan developed through the Youth Service Team process and the Individualized Education Program (IEP) development process. The individualized plan for each youth and his family includes identification of a Family Resource Team composed of agency representatives involved in the plan and identification of a case manager.

The project also includes a process for identifying a case manager for each youth through the Youth Service Team staffing process. Case managers act as liaisons between families and the Youth Service Teams to coordinate, monitor, and revise comprehensive service plans of individual students as their needs change. The project includes provisions that empower families and surrogate families to advocate for their youth and ensure that parents are full participants in all aspects of the planning, implementation, and evaluation processes of the service delivery system.

PHILOSOPHY

The values and principles defined by the Child and Adolescent Service System (CASSP) have been adopted by the Linn County Project. These values and principles, described in the introduction to this document, are viewed as ideals to strive for in providing comprehensive services.

PROGRAM/SERVICES

Regional Youth Service Teams serve all 28 school districts in the two county area. These team members allow for interagency collaboration between schools, social service agencies, law enforcement agencies, and other relevant community resources in the county. Youth Service Teams meet regularly to share information about each student, explore alternatives, and develop a plan of action to meet each student's identified needs. Each team develops its own specific processes and procedures and reflects the needs of the region it serves. A diagram of the Youth Services Team Model is included in Appendix F.

The Linn County Project has adopted the Continuum of Services for Managing Student Behavior as outlined in *A Resource Guide for Oregon Educators on Developing Student Responsibility* (Oregon Department of Education, 1989). The emphasis of the continuum is on proactively preventing problems and teaching students alternative and responsible ways to behave. A portion of the resource guide has been reprinted in Appendix F.

FUNDING

The project uses existing resources from various collaborating agencies to coordinate service delivery; no additional funding is required from agencies. The project also pursues Medicaid options, grants, and other potential resources as funding mechanisms.

EVALUATION

The Linn County project has succeeded in increasing collaboration among agencies traditionally isolated from one another. The YST process has also been effective in: developing a coordinated community plan; maintaining youth in their community; preventing the need for institutionalization; preventing duplication of resources; and increasing understanding of agency involvement and planning.

ADDITIONAL INFORMATION

Additional information about the Linn County Youth Service Teams is described in Appendix F.

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Partners Project

PARTNERS PROJECT

The Partners Project places a high priority on family placement and preservation as well as on full community integration into social, educational, and recreational activities.

OVERVIEW

The Partners Project is designed to provide an expanded system of managed mental health services to children and youth ages 5 to 18 in Multnomah County, Oregon who are experiencing severe emotional and behavioral difficulties. The goal of the Project is to assure the effective use of mental health and related services to meet the needs of youth with emotional disabilities and their families. A high priority is placed on family placement and preservation as well as on full community integration into social, educational, and recreational activities.

PROGRAM/SERVICES

The Partners Project is a consortium of state and local agencies that have agreed to work together to support a flexible pool of funds to finance and design services for these youth. Members of the consortium include Portland Public Schools, Children's Services Division, Multnomah County Mental Health, Oregon Medical Assistance Program, Centennial School District, Oregon Mental Health and Developmental Disability Services Division, and the Robert Wood Johnson Foundation. The Partners Project is one of eight sites across the country selected to participate in the Robert Wood Johnson Foundation's Mental Health Services Program for Youth.

The Partners Project uses a managed care model of service delivery and authorization; each youth and his family is assigned a Project Managed Care Coordinator. Care Coordinators work with families and involved agencies to develop individualized family service plans.

Each youth has a Service Planning Team comprised of his family members, a Managed Care Coordinator, representatives of current service providers, and potential service providers. This team assesses and prioritizes the needs of each individual and his family and designs a service package to meet those needs. The plan of care is monitored monthly and reevaluated every three months; the focus of the plan is on developing and using "natural" community support systems. Service plans build on the natural supports available to the individual and his family, such as positive personal relationships.

It is the responsibility of the Case Coordinator to arrange for the purchase of services, coordinate services and information concerning services, and assess the progress and continued appropriateness of each service for the individual and his family. These services may include evaluation, crisis treatment services, day treatment, respite care, intensive family-based treatment services, therapeutic foster care, psychopharmacology, outpatient treatment, after-school daily structure and support, transportation, individualized mental health services, community support services, and other services deemed necessary.

For adolescents in transition, project members plan with the youth and his family and other service providers to identify services needed from the adult service system, link the youth to those services, and document unmet service needs for further planning and advocacy efforts.

EVALUATION

Project evaluation data indicate a trend in stabilization among many of the youth served since the project began in August of 1990. Evidence of effectiveness includes the prevention of residential and state hospital placements; improvement and stabilization of youth in their school placements; improved living situations for youth served; and improved general functioning of the population served by this project (Cole & Poe, 1993).

ADDITIONAL INFORMATION

Additional information about the Partners Project has been reprinted in Appendix G including an article that explains how the project has influenced Oregon's statewide health care reform. A profile of the project is included in *Partnerships for Care: Systems of Care for Children with Serious Emotional Disturbances and Their Families.*

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Partnership for Family Preservation: Children & Adolescents Network of DuPage County

PARTNERSHIP FOR FAMILY PRESERVATION: CHILDREN AND ADOLESCENTS NETWORK OF DUPAGE COUNTY

Children and adolescents and their families will have access to a comprehensive array of services that address the child's physical, emotional, social, vocational, transitional, and educational needs.

OVERVIEW

This project seeks to build upon established networks and services in DuPage County, IL to provide community-based, locally managed, family-centered services for youth with emotional and behavioral disorders. The project incorporates six critical areas:

- Interagency collaboration: In DuPage County this works on three levels--county executive directors, the Partnership for Family Preservation, and Family Planning Teams;
- Target population definition: The population served by this project is children and youth, ages 0 - 21 who are at major risk and whose service needs are intense and complex, requiring interagency collaboration;
- Principles of care: These twelve principles address issues such as county-wide commitment to service which are family and child-centered, community-based and individualized;
- Needs and resource assessment: This completed assessment has helped policy makers determine the direction and nature of service delivery implementation for the county;
- Provision of services: Central to the provision of services is the coordination of wraparound services to match the strengths and needs of the youth and family; and
- Commitment to evaluation: A comprehensive commitment to evaluation monitors the services and system designed for the county.

PHILOSOPHY

The project has developed twelve principles of care that determine the context or climate in which services are delivered. These principles of care acknowledge that the system is a) to be child and family centered and community based; b) to provide assessments that identify a child's needs and strengths, that are sensitive to cultural differences, and that lead to individualized service and transition plans; c) to offer services that are comprehensive, that reflect a best practices model, and that foster self-reliance on the part of children and families; and d) to provide a system that protects and advocates for the rights of children and families. A description of these principles has been reprinted in Appendix H.

PROGRAM/SERVICES

The Partnership for Family Preservation Project has developed services based on unconditional care, intensive case management, individual planning, family involvement, flexible funding, and cultural competence. Each youth targeted for service is assigned a service coordinator who facilitates the development of a comprehensive service plan, brokers resources and services throughout the community, and monitors intervention effectiveness. An individual service plan is written by members of the intensive interagency collaborative team that reflects the identified strengths and needs of the youth and family. Family members attend planning meetings, assist in developing the service plan, help coordinate the delivery of services, work as parent advocates, and monitor the effectiveness of services. Cultural competency is achieved by carefully individualizing services around the family and culturally identified strengths and needs.

FUNDING

This project is funded by a U. S. Department of Education grant.

EVALUATION

The project has developed a comprehensive evaluation plan using both quantitative and qualitative data collection instruments. Information is being gathered in many areas including child status, family involvement, interagency collaboration, community-based services, financial costs, consumer satisfaction, and demographic information. Evaluation of this data will guide system development and growth.

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Primary Mental Health Project

PRIMARY MENTAL HEALTH PROJECT

PMHP capitalizes on the "special attributes and potentials of the young child" and the "special opportunities for constructive intervention that schools offer."

OVERVIEW

The Primary Mental Health Project (PMHP), developed by Emory Cowen at the University of Rochester in 1957, began as a small pilot project and has expanded both nationally and internationally as a flexible school-based mental health intervention program for early detection and prevention of school adjustment problems for children in grades K-3. The PMHP model has emerged as a "workable alternative to mental health's past traditional emphasis on repairing things that have gone seriously wrong" (Cowen & Hightower, 1990). At least three states in Region 6—Washington, California, and Hawaii—have developed PMHP programs. Internationally, Primary Mental Health Project programs range from Australia to Israel and provide preventive services to 10,000 children annually.

PHILOSOPHY

School mental health strategies have traditionally been "guided by a fixed orientation and set of strategies. The orientation has been toward psychopathology and dysfunction. The strategies have been to minimize or repair things that have gone wrong" (Cowen & Hightower, 1990, p. 775). In contrast, the Primary Mental Health Project uses primary and early secondary prevention approaches to forestall the development of problems and identify early signs of dysfunction among children. The program capitalizes on the "special attributes and potentials of the young child" and the "special opportunities for constructive intervention that schools offer" as natural settings for prevention programs (Cowen & Hightower, p. 776). The goal of the program is to help children begin their school years in a positive way by fostering a healthy self-concept and helping them to develop positive social skills, and skills in task completion.

PROGRAM/SERVICES

The basic structural features of the Primary Mental Health Project model are "a) a focus on young children, b) systematic use of screening and early detection procedures, c) use of nonprofessional child-aides to provide prompt, effective preventive services, and d) a changing role for the school-based professional to support a geometric increase in the reach of needed services" (Cowen & Hightower, 1990, p. 789). This structural model offers enough flexibility to be adaptable to meet the specific needs of different school communities and target populations. For instance, the Nee-Kon Project in Norman, Oklahoma is a variation of the PMHP which targets high-risk Native American children and their families.

Although no single program description can fully capture how PMHP operates in all schools, the following components are usually present in some form:

- Objective screening measures to provide profiles of children's school problems and competencies;
- Referrals are made by teachers, school personnel, and parents;
- Screening and referral data are reviewed by the PMHP team consisting of the principal, school mental health professionals, teachers, and child-aides; this team meets regularly to exchange information and coordinate goals;
- Child-aides serve as direct service agents to 13 - 14 children at a time; these aides receive specialized training and are supervised by school mental health professionals;
- Midyear and end-of-year conferences are scheduled to evaluate children's progress and make recommendations for the future;
- PMHP consultants visit schools on a regular basis to offer support and guidance;
- The school professional's role has shifted from the traditional model of one-to-one services to an emphasis on training, consultative, and resource activities for school personnel.

Other services offered by Primary Mental Health Projects include home visits, parent groups, crisis intervention, referral of students and families to community agencies, and follow-up. In Honolulu the model has added a family focus. Counselors, child aides, and social workers provide direct services to project students as well as their siblings and family members.

More recently the PMHP approach has expanded its approach to promoting the well-being of all children. This expansion includes a) educational programs to build social competency; b) changes in class environments and practices to enhance learning and psychological wellness; and c) preventive programs for children who have experienced stressful life events. PMHP has developed several training curricula to teach young children problem solving, realistic goal setting, appropriate assertiveness, and critical thinking skills.

EVALUATION

Multifaceted research has been ongoing since PMHP's inception. At least 20 outcome studies have verified the program's effectiveness in terms of educational achievement and behavioral adjustment (Knitzer, Steinberg, & Fleisch, 1990). Research findings have been beneficial in strengthening program practices and extending the program's range of applicability. Several states, among them California, have enacted legislation with budgets supporting PMHP replication, which has increased the numbers of school districts implementing the program. "Thus the PMPH experience has had some visible impact on how school mental health services are conceptualized and delivered, and on the difficult challenge of bringing about constructive social change" (Cowen & Hightower, 1990, p. 789).

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Project Connect

PROJECT CONNECT

For students with intense needs, more varied and intense resources are provided, but not necessarily in more restrictive settings.

OVERVIEW

Project CONNECT is a federally funded project in its second phase that is working to implement a needs-based model of services for students with emotional disabilities in two participating school districts—one rural and one urban—in the Indianapolis, Indiana area. This needs-based model is based upon offering services in the least restrictive environment, providing a full continuum of service options, basing service decisions on social, academic, and behavioral needs of students rather than categorical labels, and making resources available to help students with more varied and intense needs rather than placing them in more restrictive settings.

According to the project's continuation proposal, the needs-based model includes five major components:

- Establishing the position of a Family Services Coordinator. The Family Services Coordinator acts as a child and family advocate working to provide effective service coordination, a single point of access to services for parents, a focus on child advocacy, and a nucleus point around which to develop a network of coordinated services for youth and their families.

- Creating district Family Services Coordinating Councils. Family Services Coordinating Councils act as a central point of contact and collaboration between various service agencies. They are responsible for working with Family Services Coordinators in reviewing referrals, monitoring and evaluating child service plans, and coordinating planning and development activities designed to respond to identified weaknesses and needs of the system of child-serving agencies.

- Developing and implementing Individual Family Services Plans. Family Service Plans guide the planning and implementation of coordinated services determined by the family and its Family Services Coordinator.

- Utilizing a Systems Change Facilitator. The Systems Change Facilitator works to coordinate and expedite broad strategies for improving services to each participating school district. This responsibility may be met in a number of ways, including 1) training building-based personnel in procedures for managing inappropriate behavior and teaching social skills; 2) supporting the developing of pre-referral intervention teams; 3) assisting related services personnel in revising assessment procedures; 4) facilitating building-based planning teams; 5) organizing and supporting the local Family Services Coordinating Councils; 6) developing various interagency agreements or service linkages, cost sharing, and joint ventures; 7) locating sources of funding for creating service options; and 8) providing assistance in training related services personnel in collaborative case management and family support planning.

- Implementing Project CONNECT modules. Project CONNECT has developed two unique "self-study" modules designed to be used by school districts to replicate the systems change process, train personnel, and introduce new strategies for providing services to students with disabilities. The modules, "Working Together: Building Interagency Collaboration for Challenging Students" and "Moving Toward LRE: A Needs-Based Continuum of Services with Emotional Handicaps," have been completed and are being field tested.

PROGRAM/SERVICES

During the first phase of the project four areas of need were identified. Specific objectives intended to meet those needs during phase two are outlined here:

Interagency Cooperation. New models that better facilitate interagency collaboration are needed for students with multiple needs.

Objectives:
1) Establish the role of Family Services Coordinator in each participating school district; 2) Organize Family Services Coordinating Councils in each district; 3) Establish use of the Family Services Plan in each participating district; and 4) Field test and revise the Interagency Development Module developed during phase one as a resource for planning and promoting interagency collaboration and cooperative agreements.

Parent Involvement. School personnel must have access to information that will allow them to increase parental involvement and coordinate with other agencies to meet youth and family needs.

Objectives:
1) Increase and enhance family involvement through education and information sharing; 2) Increase family involvement through the development of parent participation programs; and 3) Enhance family involvement through the use of the Family Services Plan and contact with the Family Services Coordinator.

Continuum of Services. An effective and complete continuum of services must exist that stresses movement toward the least restrictive environment and service in the home community.

Objectives:
1) Work with other community agencies in developing placement alternatives in the community for youth; and 2) increase the number of building-based treatment options in participating districts by field testing the Continuum of service module developing during Phase One.

Curriculum and Behavior Management. Effective strategies in curriculum and behavior management that stress adaptation, self-control, and functional life skills must be brought to bear in programs for youth with emotional disabilities.

Objectives:
1) The Systems Change Facilitator will provide training for building personnel to increase curricula appropriateness for youth with emotional disabilities, including vocational training, social skills training, appropriate curricular placement, and life skills training; 2) The Systems Change Facilitator will work to improve training for building personnel in basic behavior management techniques; and 3) Develop a building ecology that is conducive to meeting the needs of youth with serious emotional disturbance.

FUNDING

Support for this project is being provided through a grant from the U. S. Department of Education and the Indiana Department of Education. Participating school districts have paid a portion of personnel costs.

EVALUATION

Progress has been made in the participating districts toward implementing all of the objectives specified for phase two. According to the project's continuation proposal, Family Service Coordinators and Systems Change Facilitators are in place in both participating districts. Eventually these responsibilities may be fused into one position, especially in rural school districts. Family Service Coordinating Councils have met in both districts and are in the process of developing Memorandums of Understanding. A model for family-based teams to develop Family Support Plans is in place in both districts. The Systems Change Facilitators in both districts are exploring and opening new services and contacts with other agencies. And, Project CONNECT modules are being used to improve interagency collaboration and to implement a need-based model of service delivery in both districts.

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Project Wrap

PROJECT WRAP

'Wrapping' a child or youth with supportive services is respectful of the individuality of the child and focuses on identifying and building upon the existing strengths of the child and his family.

OVERVIEW

Project WRAP is a school-based systems change initiative in Illinois for youth with emotional and behavioral disabilities and their families. Project WRAP is a federally funded project awarded to the La Grange Area Department of Special Education that "wraps" networks of support and services around students and families in natural home, school, and community settings. According to literature provided by the project, the ultimate goal of Project WRAP is to "integrate wraparound strategies and more inclusive options into the existing service delivery system and retrain service providers to facilitate these innovative approaches which are proving more effective for children and families" (Eber, 1993, p. 1). Parents, school personnel, mental health providers, and student peers are all working together in the project to reshape services and refocus traditional resources into a more effective family-friendly support system (Eber, 1993).

Phase one of Project WRAP focused on evaluation and assessment of the existing interagency system while new approaches to providing wraparound services were piloted with 15 targeted youth and their families. The work completed in Phase one has resulted in the development of a case coordination system that redirects state and local resources across educational, mental health, and other agencies to provide wraparound services for youth and families in homes, schools, and communities.

As a result of phase one of the project, there has been a decrease in reliance on categorically designed services; parents have become case managers for their own families; in-school respite supports have been provided to facilitate inclusion; mental health services have been integrated into schools; school-wide peer support programs have begun; and parents have become advocacy partners for improved services. An interagency service network, interagency coordinating council, and parent network are all in place as the result of the project's first phase.

The assessment completed during phase one of the project took a comprehensive look at existing services and needs from several perspectives. The critical needs that emerged from this analysis are outlined in Appendix I (Eber & Stieper, 1993, p. 12 - 14). Discussions with parents, especially the 15 families involved in the pilot program, highlighted the need for family support teams, individualized and strength-based planning, and normalized service delivery in home, school, and community settings.

The system gap revealed most clearly during the assessment process was in services to the adults who raise, teach, and guide these students. Whereas services have traditionally centered on the student and his behavior problems, parents and school personnel indicated they wanted someone to work with them in meeting the needs of these students. Parents indicated a strong need for support that would allow them time and energy to meet their own needs, which are so frequently buried beneath the intensive needs of their children. Both school personnel and parents indicated they wanted an alliance that would help them develop, access, fund, and coordinate services to help the children they raise and teach.

Phase two of the project involves moving from planning and pilot efforts to full implementation of a comprehensive systems change plan that includes more inclusive services, respite services, parent organizations, family-focused service planning, and expanded case management services. Model system components of both phases of Project WRAP are outlined in Appendix I (Eber & Stieper, 1993, p.5).

The Wraparound in Schools (WAIS) model promises more effective and inclusive options for students with emotional disabilities placed in regular school settings. This model builds on student strengths and uses in-school respite, team teaching, and peer supports to include in a variety of school settings students who were once restricted to self-contained environments. WAIS also creates new roles for teachers who are "beginning to function in a wraparound facilitation role rather than a self-contained teacher mode." Roles for teacher aides, social workers, and other support staff are being redefined as well under this inclusive model.

PHILOSOPHY

"Wrapping" a child or youth with supportive services is respectful of the individuality of the child and focuses on identifying and building upon the existing strengths of the youth and his family. The concept is family centered and parent driven. "Wrapping" reduces family stress by assisting families to navigate their way through the social service system and by providing networking opportunities and emotional support for families.

PROGRAM/SERVICES

The goal of Project WRAP is to keep youth in school and in communities with their families. This goal has led to the development of non-categorical wraparound supports for youth and families. Planning focuses on more responsive instead of more restrictive options. Interns from Forest Hospital Clinical Psychology Internship Program and Family Therapy Training Program as well as staff members from La Grange Family Services have joined school personnel in providing services to students and their families in school settings. The following are some of the initiatives associated with the project:

Wraparound Interagency Network (WIN): This network is an alliance of state and local community service agencies and parents that coordinates and integrates services for students with emotional and behavioral disabilities and their families. A Coordinating Council of representatives meets monthly to work together on policy development and service delivery, and to provide consultation to families requesting assistance. The goal of the network is for every child to have a team (parents and agencies) to plan, implement, evaluate and revise his/her support plans.

WRAP Parent Network: This parent network has been formed to advocate for more family-friendly services. Together with the Interagency Coordinating Council, the Network focuses on influencing state-level collaboration around funding, regulations, and incentives for inclusive community-based services.

Parent Partners: Parent-to-parent mentoring is made possible through this support network. Parents receive emotional support, encouragement, and understanding from other parents with similar experiences, which is especially helpful during times of crisis.

Peer Support Programs: An important component of the Wrap Around program is peer support models in schools and in the community. Several different models have been initiated in pilot schools. These programs offer tutoring support as well as recreational opportunities for students to interact with their peers.

Buddy Program: The Buddy Program recruits 17 to 25-year-old males to provide social and recreational opportunities for designated students. Buddies provide positive peer acceptance and role modeling in school and community settings.

Respite: Respite services provided through wraparound services include school respite for behavioral support in regular education classes; in-school or in-home respite that focuses on tutoring, completing homework, and learning organizational and study skills; in-home respite for behavioral support, supervision and assistance for parents; and community respite to foster integration in community activities.

FUNDING

Project WRAP is supported by both federal and private grants as well as by several community agencies working in collaboration with the school system.

EVALUATION

During phase one of the project, students have been returned from residential placement while others have been retained in their communities instead of being placed in residential settings. The foundation of natural supports and local collaboration built during phase one will allow for more care within the home and community and a continued downscaling of residential placements as the project progresses, according to project literature.

ADDITIONAL INFORMATION

Additional information about Project WRAP is included in Appendix I.

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Regional Intervention Program

REGIONAL INTERVENTION PROGRAM

Parents participating in the RIP Program become trained as therapists for their own children and act as primary resources to each other.

OVERVIEW

The Regional Intervention Program (RIP), founded in 1969 in Nashville, Tennessee, represents a pioneering approach to the delivery of community-based, family-centered services. This early intervention effort has been replicated in more than 20 communities in the United States as well as in some foreign countries. The only RIP site in Region 6 began operation in Yakima, WA during the spring of 1994.

The RIP program serves children six years old and younger who have disabilities, including emotional/behavioral problems. Parents participating are trained to be therapists for their own children, principal trainers of other parents, and daily operators of the service delivery system. "The cornerstone element of the entire model is parent implementation—an approach that recognizes the family's pivotal role in most young children's lives and the value of asking parents to take the first steps toward desired change" (Timm, 1993, p. 40).

PHILOSOPHY

The RIP program model defines behavioral/emotional disorders as "manifestations of disorders within a small social system of which the child is but one inseparable part" (Timm, 1993, p. 35). Treatment efforts then address not only the child's "presenting needs" but the interdependent parts of his "human ecosystem" as well. The RIP program model regards the family as the basic unit of change and engages family members actively in the treatment process. It operates on the principle that families with young children who have special needs also have "remarkable capacities for helping themselves and each other" (Timm, p. 41).

PROGRAM/SERVICES

The criteria for admission to the RIP program are a) a family's serious concerns about their child who is six years old or younger, and b) an agreement that at least one parent will work at the RIP center with his or her child and with other adults and children a minimum of three mornings or three evenings per week.

Family participation in the program is organized in two phases—treatment and payback. During treatment, parents work with their own children at the center and at home. They engage in activities such as family treatment sessions, feedback sessions, group discussions, and instructional videotape viewings. They also perform tasks such as teaching, collecting data, preparing snacks, or working in the sibling nursery.

After completing the treatment phase, parents begin the process of payback to the program for the services they have received. During this phase parents provide assistance to newer families in the program. The payback phase allows parents who began as novices to assume more responsibility for more complex tasks in the program as seasoned veterans. They observe individual therapeutic sessions, offer feedback, record and analyze data, serve as lead teachers, provide classroom training, and develop instructional materials. During the payback phase families may continue to bring their children to the program but are not required to do so. All families are provided the opportunity to pay for RIP services with time and skills rather than money. They perform a wide range of clinical and administrative functions done by professional staff members in many other programs. The continual payback system allows RIP to constantly replenish its supply of enthusiastic parent teachers and maintain a strong self-help group for support.

At the time of a family's enrollment in the program, clinical responsibility is assigned to a professional resource staff member. This staff member assists in the development and ongoing revision of the family's treatment plan; monitors efforts designed to meet family treatment objectives at RIP, home, and other places; helps to secure resources in the community to meet child and family needs; and prepares written reports.

Each participating family also has a case manager (successful graduates of RIP who have been invited to remain as paid RIP staff members) who assists in developing the family's treatment plan, coordinates daily treatment sessions, and assists in designing and monitoring daily living programs conducted in community settings. Since case managers are parents who have successfully completed the RIP program, they are able to give new families the extra support they need as they begin the process.

All families participate in the preschool classroom module. Under the supervision of enrolled parents acting as teachers and teaching assistants, parents work with each other's children, teaching them skills that will enable them to function effectively outside of the RIP environment. Preschool siblings of participating children serve as models in the classroom. Children may also participate in more specific modules such as Behavior skills training, Developmental skills training, and Day care intervention, depending upon their individual needs. Participating children and their families average 54 visits over a 20-week period of treatment.

FUNDING

Funding approaches vary, depending on the community site of each RIP program. Some are funded through state mental health dollars; others are supported by local/regional mental health centers. Still others use a blended funding model with funding coming from both education and mental health.

EVALUATION

Several evaluation studies have indicated positive cost and program benefits for the Regional Intervention Program (Timm, 1988). A 1982 follow-up study of 40 "graduates" of the RIP program and their families showed, among other findings, that graduates' social interactions in the home were overwhelmingly positive and their nonsocial behavior was by and large appropriate (Timm, 1988). Parent behavior in the home was found to be consistent with the child management skills taught in RIP three to nine years later. The study examined several demographic variables as they related to current levels of behavior. Of particular interest was the significant evidence found that the younger the child was during RIP treatment, the more successful was his adjustment three to nine years later.

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SEDNET
(Multiagency Service Network for Students with Severe Emotional Disturbance)

SEDNET
(MULTIAGENCY SERVICE NETWORK FOR STUDENTS WITH SEVERE EMOTIONAL DISTURBANCE)

Under the direction of SEDNET, system philosophy has shifted from "deep-end services" to "front-end prevention" in many regions of the state.

OVERVIEW

The Multiagency Service Network for Students with Severe Emotional Disturbance (SEDNET) was created to develop a multiagency network in the state of Florida to provide education, mental health treatment, and, when necessary, residential services for students with emotional disabilities. SEDNET was initiated in 1981 in response to increasing numbers of out-of-home and school placements.

The Network includes representation from the Florida Department of Education, the Bureau of Education for Exceptional Students, the Alcohol, Drug Abuse and Mental Health Program Office of the Department of Health and Rehabilitative Services, participating school districts, community mental health centers, children, families, and others. A State Advisory Board is responsible for development and maintenance of the statewide multiagency service network as well as oversight of regional projects. SED Network Regional Planning Teams focus on county-level service development and the functioning of the case management system.

PROGRAM/SERVICES

The emphasis of regional projects is to enhance existing community relationships to provide appropriate education, mental health treatment, and, when necessary, residential services for students with emotional disabilities. Regional projects vary depending upon local priorities, needs, available resources, talents, and opportunities. Although each project is unique, they share four common goals outlined in SEDNET's *First Annual Report*. These are to 1) provide a system to monitor and promote a comprehensive system of care which includes education, mental health treatment, and residential services for students with emotional disabilities; 2) increase the effectiveness of existing education, mental health treatment, and residential services; 3) maintain the system for continuous multiagency planning, implementation, and evaluation of education, mental health treatment, and residential services; and 4) share information, materials, and resources for services to students with emotional disabilities (*First Annual*, 1993 p. 20).

A Family Service Planning Team, including representatives of service agencies and families, develops individualized service plans for youths and their families and uses wraparound monies to purchase services. Case Management Teams, organized by SED Network case managers, implement the family service plan. A Case Review Committee is a multidisciplinary team that reviews all referrals for residential treatment and makes placement recommendations.

Services offered through regional networks include assessment, day treatment, home-based counseling services, crisis intervention services, crisis residential services, on-site clinical services in schools, substance abuse services, therapeutic foster care, therapeutic group care, individualized wraparound services, residential treatment services, inpatient and outpatient services, and parent group support.

EVALUATION

According to its first annual report , SEDNET has reduced the number of students in residential treatment. Costs shared under the community-based plan have consistently run at about one-fifth the cost of residential treatment, giving the state increased capacity to improve its system of care and extend services to more youth. With increased family participation, Family Service Planning teams have been able to assist students released from residential treatment to reintegrate into less restrictive environments and thus maximize the benefits of the program. The system's philosophy has shifted from "deep-end services" to "front-end prevention" in many regions. Regional network projects have "demonstrated the ability to bring about interagency planning, develop cooperative service and funding agreements, integrate policies and procedures and implement innovative programs" (*First Annual*, 1993, pp. 9 - 10). Additionally, these projects have succeeded in refining individual treatment and educational plans, preventing duplication of services, and providing joint inservice training for school and mental health personnel, according to the report.

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Southern Westchester IDT (Intensive Day Treatment) Program

SOUTHERN WESTCHESTER IDT (INTENSIVE DAY TREATMENT) PROGRAM

The IDT program uses individual, family, and social interventions on a short-term basis to return crisis behaviors to more stable, pre-crisis conditions.

OVERVIEW

The Southern Westchester Intensive Day Treatment (IDT) program offers an alternative to hospitalization of children and youth in crisis living in the New York counties of Orange and Westchester. The program, a collaborative effort between the Southern Westchester Board of Cooperative Educational Services and the Rockland Children's Psychiatric Center in cooperation with the Westchester County Department of Community Mental Health, supports children and youth ages 6 to 18 in crisis by using individual, family, and social interventions "on a short-term basis to return crisis behaviors to pre-crisis conditions," according to literature provided by the program.

PROGRAM/SERVICES

IDT provides evaluation, treatment, and educational services to students with emotional disabilities for a maximum of 30 days. Medication and family intervention techniques are used to help stabilize youth. Parents participate fully in treatment and crisis intervention, receiving support from IDT professionals as they help their children take control of their lives.

During the treatment period, educational services provided by IDT are based on academic work provided by the home school. Communication and cooperation between the home school and IDT is crucial to the success of the student. Transition back to the home school begins within one week of admission to the IDT program. The student in transition returns to the home school with a planned and carefully monitored partial schedule of activities while he still attends IDT for treatment and support. IDT provides discharge planning and comprehensive after-care services to the family and the home school.

IDT also offers short-term, transitional services for adolescents discharged from psychiatric inpatient settings. These services foster social, educational, and family adjustment in a supportive environment with comprehensive clinical services.

The IDT team consists of mental health professionals, who do evaluations and design treatment plans to stabilize and improve behavior; a teacher, who is responsible for developing an educational plan and implementing programs from the home school; school liaisons designated from each school district, who coordinate academic work and facilitate reintegration of students into the home school; home school teachers, who coordinate continuing education efforts with the IDT teacher and help facilitate the return of the student; and interagency planning group representatives from mental health and education, who discuss, evaluate, and recommend modifications in treatment plans.

FUNDING

The Southern Westchester Intensive Day Treatment program has interdisciplinary and multi-agency regulations and funding, with links to community mental health and educational systems. Student evaluation and treatment planning are offered at no cost to local school districts. The only cost borne by the school district is for educational services.

ADDITIONAL INFORMATION

More detailed information about Intensive Day Treatment programs operating in Westchester and Orange Counties, New York has been reprinted in Appendix J.

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Stark County System of Care

STARK COUNTY SYSTEM OF CARE

The Stark County system of care focuses on the strengths of the youth and family served rather than on pathology.

OVERVIEW

The Stark County, Ohio system of care integrates interagency efforts with the goals of building a unified system of service delivery, providing services which enable youth to remain in their homes and communities to the greatest extent possible, and reducing the numbers of youth in out-of-home and out-of-county placements.

Stark County began interagency planning and collaboration before it was mandated in 1987 by the state of Ohio. This legislation requires state and local agencies to cluster and coordinate services for multi-need youth. The organizing structure for the system of care in each county is provided by the cluster. The Stark County Interagency Children's Cluster is the structure for system-level coordination for the county's system of care. All involved agencies, including representatives from mental health, health, education, juvenile justice, child welfare, mental retardation, and substance abuse, participate in varying degrees in the organization and operation of the system of care.

In addition to the cluster, there are several other interagency endeavors where collaboration is building service capacity. Among these is the School and Agency Advisory Council comprised of representatives from all school districts in Stark County and from all the human service agencies. The Council informs schools and human service agencies on a regular basis of what services are available and how to access those services.

PHILOSOPHY

Central to the philosophy of the Stark County system are four basic elements:

- Interagency collaboration: This system of care is based on the premise that no agency alone can be as effective individually as they can be together, and that no single agency has the ability or resources to meet all the needs of a youth and his/her family.

- Providing services within the home and community: The system has a philosophical commitment to provide services in the least restrictive environment and to keep youth with their families and in the county to the greatest extent possible. The program wraps services around the needs of the youth/family and provides "whatever it takes!" to make a difference.

- Family focus: In order to support positive family functioning, the system focuses on the needs of the entire family and on involving parents as partners in service efforts.

- Strengths focus: The system also focuses on the strengths of the youth and his family rather than on pathology.

The elements of this philosophy are embedded in the Stark County System of Care's vision statement, which reads:

> We visualize a unified system that energizes all services around each child's needs so they can realize their maximum potential. This system provides positive alternatives within the community so that the child will have the opportunity to build on his/her strengths. This system effectively supports positive family functioning and nurtures children in a socially, emotionally, and educationally sound environment which persists into adult life. (Stroul, Goldman, Lourie, Katz-Leavy, & Zeigler-Dendy, 1992, "Stark County," p. 9)

This program has an unconditional care commitment and a belief that everyone has self-worth and that change can occur. The community is viewed as part of the solution, not the problem, and parents are involved as partners in the "definition of issues as well as the solutions."

PROGRAM/SERVICES

Stark County offers an array of services for youth with emotional disabilities and their families. These include:

Prevention and Early Intervention: Stark County offers an assortment of prevention and early intervention services. For young children aged three to five the Canton City Schools provide preschool programs for at-risk children, and the Child and Adolescent Service Center provides mental health services through the Head Start Program. The county has also started a Preschool Community Services program for children birth to five years of age, with a major focus on children with emotional disabilities. Combining a center-based and home-based approach, early childhood interventionists in this program provide clinical and case management services to children and their families as well as consultation in regular preschool settings.

Elementary Programs: A program entitled Friends Can Keep You Healthy was initiated as a collaborative effort between the Child and Adolescent Service Center and the Canton City School district . The program offers biweekly support meetings for small groups of elementary school students in inner city schools. This support is intended to promote positive feelings among these youths toward themselves and others.

An At-Risk Dropout Prevention Grant targets high-risk elementary schools to try to minimize future mental health and educational problems. The grant provides therapeutic services in school settings for individual students as well as groups of students and parents. The grant also funds behavior adjustment classes where individual behavioral plans for each student are developed with parent participation.

Secondary Programs. On the secondary level, the Child and Adolescent Service Center offers training to adolescents ages 15 to 17 to serve as peer listeners in the Peer Listening Program. Adolescents training in the program offer confidential active listening, support, information, and referral to their peers to help resolve problems.

Outpatient Services: Stark County's Child and Adolescent Service Center offers a range of outpatient and treatment services, including assessment, counseling services in the home, school, and community centers, group counseling services, and parent training.

Home-based Services: The Stark County system of care provides both short-term and longer term home-based services. The short-term program, Therapeutic In-Home Emergency Services (TIES), is a crisis-oriented program that serves youth with emotional disabilities who are at risk for out-of-home placement by helping to solve problems within the home and family. TIES therapists are available 24 hours a day and typically spend an average of 6 to 10 hours per week with a family for a service duration of 12 weeks. Services are based on an individualized treatment plan for the youth and family, including crisis intervention, individual and family therapy, case management, and a range of support services.

The Intensive Home-based Services program offers longer term services to youth who are returning home after long-term psychiatric care or other residential placement to help them reunite with their families. Therapists are available 24 hours a day and work with families for an average of one year. They offer individual and family therapy, provide case management, provide access to needed services and resources, and generally help stabilize the family and prevent a return to long-term psychiatric or residential care.

Day Treatment: Stark County's Day Treatment Program serves students aged 5 to 17 with emotional, behavioral, and/or social problems significant enough that they cannot be adequately treated with less restrictive therapeutic or educational services. The psychoeducational program is a collaborative effort between the education and mental health systems in the county.

Classroom structure emphasizes positive reinforcement, and multidisciplinary treatment teams provide a variety of specialized services. In addition to the mental health and educational services that form the core of the program, students receive extensive case management services, social skills training, recreational services, speech and language programming, and other related services. A psychiatrist works with the program on a part-time basis providing consultation to staff, class observations, and individual treatment. Family involvement and participation is considered an essential part of the program; in turn, parents are provided information as well as support.

The average stay for a student in the day-treatment program is 18 months. Transitions back to regular public schools are attempted whenever possible and take place gradually. Case management and outpatient mental health services are continued during and following the transition period.

Crisis Services: A variety of crisis services are offered by the Crisis Intervention Center of Stark County, including telephone crisis services through a 24-hour hotline, outreach services, walk-in crisis services, and short-term residential services.

Respite Services: The Tri-County Easter Seals Society offers in-home respite care, out-of-home respite, and emergency respite. Trained respite providers offer families a break from the physical and emotional demands of parenting.

Residential Services: Residential care options include therapeutic foster care, group homes, and inpatient psychiatric services.

FUNDING

Primary strategies used to finance the Stark County system of care include funding of services through the mental health system, interagency funding, joint funding of service components and programs, and maximizing all potential funding sources for services, including Medicaid. Interagency funding of services for individuals is determined by the Cluster. Funds flowing through the Mental Health Board to the service system include state general revenue, block grant funds, and a local community mental health board levy.

EVALUATION

Stark County has made substantial progress toward creating a community-based system of care that includes a broad array of services and interagency coordination mechanisms at both the system and client levels. Out-of-county residential placements have been reduced significantly while more students are being educated in the least restrictive, most normative environment (Stroul, Goldman, Lourie, Katz-Leavy, & Zeigler-Dendy, 1992, "Stark County").

ADDITIONAL INFORMATION

A more detailed description of the Stark County System of Care is reprinted in Appendix K.

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Ventura County Mental Health Children and Adolescent Project

Ventura County
Mental Health
Children and
Adolescent Project

VENTURA COUNTY MENTAL HEALTH CHILDREN AND ADOLESCENT PROJECT

The core value of the Ventura Project is that a community-based, interagency system of mental health care that targets the most disturbed youth will provide the greatest benefit to these individuals, their families, and the community at the lowest cost.

OVERVIEW

The Ventura County Project, considered a leader in the development of local systems of care for children and youth with emotional disabilities, was one of the pioneer efforts in the country to offer an approach to services that involved interagency coordination and collaboration, a comprehensive array of services, and community-based care.

The building blocks for the Ventura system of care were first laid in the early 1980s. Then, with the passage of a critical piece of legislation in 1985, AB 3920, the Ventura County Children's Mental Health Services Demonstration Project was born. This pioneering legislation established a two-year demonstration project and directed Ventura to develop a model for a comprehensive, coordinated mental health system that could be replicated in other counties. More recent legislative action in the state has expanded the model and supported its replication.

The five essential elements of the Ventura Planning Model are derived from this philosophical foundation. These generic principles are applicable to other communities organizing systems of care:

- A clearly defined set of targeted populations that include those youth who are at greatest risk of out-of-home placement and for whom the public sector already has legal and fiscal responsibility;
- Measurable goals that are committed to the preservation of family unity and locally-based treatment;
- The development of viable partnerships at the policy, planning, and service level between public sector agencies, between the public and private sectors, and between agencies and families;
- The development of collaborative program services and standards that adhere to the service philosophy of family preservation, family reunification, and least restrictive environment--developing service plans tailored to an individual child and family and having available a continuum of service options and settings that cross agency boundaries; and

- The development of a mechanism and process for system evaluation that measures client outcome and costs over time and across programs and ensures system accountability. (Goldman, 1992, p. 7)

The Ventura County Project is based on the concept that mental health services should be integrated into the service systems of agencies concerned with the needs of children and youth. In Ventura County these agencies include Juvenile Justice, Special Education, and Child Welfare.

PHILOSOPHY

The core value of the project is that a community-based, interagency system of mental health care that targets the most disturbed youth will provide the greatest benefit to these individuals, their families, and the community at the lowest cost. Similarly, the program is based on beliefs that the system of care should be child centered and family focused, with the needs of the individual and his family determining the services provided. The Ventura Project is also based on the belief that systems of care should be community based, with the locus of services as well as management and decision-making responsibility remaining at the community level.

PROGRAM/SERVICES

The array of services offered by the Ventura County Mental Health project include 1) prevention, 2) emergency services, 3) outpatient treatment, 4) enhanced special day care classes, 5) day care services, 6) case management, 7) crisis intervention homes, 8) enriched foster homes, 9) transitional residential care, 10) acute psychiatric hospital care, 11) long-term residential care, and 12) secure regional intensive treatment center care. Flexible dollars can be used across the different services offered in the program.

Ventura County Mental Health serves as the system's core and provides specialized services to each of the other collaborating agencies. Roles and relationships among these agencies are described in interagency agreements that delineate joint administrative, fiscal, and service responsibilities. The Ventura County system of care is also linked through several interagency coordinating mechanisms, including the Interagency Juvenile Justice Council, which is a policy-making body, and the Interagency Case Management Council, which serves as a vehicle for case resolution and identification of service system gaps and problems. Representatives from public agencies that are a part of the interagency network serve on these councils.

Interagency collaboration also occurs between the public and private sectors in the Ventura County system. This collaboration takes place through a number of public/private sector boards, projects, and service contracts with private, nonprofit agencies. The Resource Development Project is one such example, which maintains a bank of goods and services donated to assist youth and matches needs with donations. The project is operated and staffed by a local, nonprofit social service agency with additional support from United Way funds.

Although the Ventura County system focuses on high-risk youth, a primary prevention program for young children is part of the service system as well. The Primary Intervention Program (PIP) is a school-based program for young children in grades kindergarten through third grade who are experiencing difficulties in school. The program helps these students develop healthy self-concepts and good social and academic skills.

In Ventura County, mental health services follow the individual; an array of services is provided to enable youth to remain in the county and in their homes whenever possible. By integrating mental health services into each system, there is less need to refer an individual to a state hospital or residential treatment center. In this way, community-based services can serve as an alternative to more restrictive placements.

Mental health is fully integrated in the special education process. Entry into the mental health/special education system requires assessment by both agencies. The mental health professional who conducts the initial assessment becomes part of the student's IEP planning team. A range of service options has been developed that combine staff and funding from both Mental Health and Special Education.

Placement options for students with emotional disabilities range from preferred least restrictive alternatives to less preferred, more restrictive alternatives. On the continuum of least restrictive alternatives, students may stay in their local schools and receive supportive mental health services, including outpatient treatment and in-home services. Day treatment programs for elementary and high school students are co-staffed by mental health professionals and special education teachers. Enhanced special day classes on regular school campuses are staffed by both mental health professionals and special education teachers. Only those students who have exhausted all local, less restrictive options are referred to more restrictive, residential programs.

A closer look at two least restrictive options--Enhanced Special Day Classes and the Phoenix Program--follows:

Enhanced Special Day Classes: Special classes located on neighborhood school campuses offer special education and mental health services for students with emotional disabilities. In addition to the special education curriculum, mental health interventions include direct therapeutic intervention (individual, group, and family therapy); consultation to the classroom teacher; collaboration between mental health, special education, and regular education staff; and coordination with other agencies. Students assigned to these classes participate in school activities and often attend regular education classes.

The Phoenix Program: The Phoenix School, which serves secondary students, and the Phoenix Elementary Program are day-treatment programs co-operated by mental health and special education. A mental health case manager coordinates placement and services. The Phoenix Program is intensive and limited to one year, *including a summer extended school program*. Each class is limited to eight students. Education and mental health staff members provide a combined program of special education and mental health treatment based upon the individual student's IEP goals. Each of the three classes has a full-time special education teacher and an educational aide. A full-time mental health professional serves all three classes, providing crisis management, problem solving, and social skills training on a rotating basis. Two full-time mental health clinical social workers provide family, individual, and group therapy as well as community linkage. On-site psychiatric consultation is also provided. The program is supervised by a principal from education and a clinical psychologist from mental health. Regular team meetings are held to coordinate services. The school staff meets with families at least twice monthly. Family services are an essential part of each student's IEP and Mental Health Treatment Plan.

Students in the Phoenix program are taught coping skills, such as stress reduction, social skills, family living skills, problem-solving strategies, and classroom study skills. A positive, group-oriented, social climate is encouraged in the classroom to encourage academic learning and prosocial behavior. Individual IEP plans are maintained to help meet each student's unique needs. Secondary students continue basic academic work and earn credit towards high school graduation.

The Phoenix School uses a "Time-In" process for students who need intensive intervention during times when their behavior is out of control. When a student is sent or self-refers himself to the Time-In room, a counselor works with the student to regain control, using techniques such as progressive relaxation. The counselor then guides the student through a process to identify and clarify the problem, outline actual responses, list alternatives, consider consequences, and evaluate results. Counselors use role playing, assertiveness training, social skills training, and stress inoculation techniques to help these students learn coping skills.

Transition planning begins halfway through the year-long treatment program. Three months prior to the student's reintegration back to his home school, the student may "transition" back to school for partial periods. A resource specialist works with home school teachers to provide training and assistance with the reintegration process. After this period of transition, mental health may continue to offer case management and outpatient services.

FUNDING

Financing for the Ventura County system of care involves multiple agencies and funding sources. All county systems of care programs that involve more than one agency are jointly funded and staffed. Ventura County's public agencies have formed a consortium to develop interagency fiscal strategies to maximize federal resources through more effective use of existing state and county funds.

EVALUATION

Various evaluations of the Ventura Project evidence the following results:

- A reduction in out-of-county court placements,
- A reduction in the rate of recidivism among juvenile offenders,
- A reduction in the rate of state hospitalization of youth,
- An increase in the number of students at risk of placement being served by intensive in-home crisis treatment programs and remaining at home at least six months, and
- Significant gains in school attendance and academic performance of students attending Phoenix School. (Goldman, 1992)

California has passed legislation encouraging other counties to replicate the Ventura model, and it has been used as a blueprint for similar programs nationwide.

ADDITIONAL INFORMATION

A more detailed description of the Ventura County Project is included in Appendix L.

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Vermont New Directions

VERMONT NEW DIRECTIONS

Recognizing that a youth with an emotional disability is likely to experience periodic crises, the Vermont program places a special focus on crisis stabilization and respite.

OVERVIEW

Vermont's New Directions project is unique in that it has been statewide in scope from inception. New Directions has built upon a tradition of strong family and community-centered care already in place in the state to develop a comprehensive system of community-based care statewide through the support of interagency collaboration, development of new service capacities, and the restructuring of funding mechanisms. The project implements core service components of its system of care throughout the state while also providing start-up funding for high-need services in particular localities.

Vermont's system of care plan was codified into law in 1988 as Act 264. This Children's Mental Health Act developed a statewide System of Care Plan which is updated and submitted to the General Assembly each year. The law also created a statewide system of local interagency teams, one in each of the state's 12 social service districts. These teams are comprised of local agency and parent representatives who work together to deliver services to multi-need youth. District teams work with local treatment teams to develop individualized service plans.

The law also created a Governor's Advisory Board made up of five parents, five advocates, and five professionals, who make broad policy recommendations, and a State Interagency Team, whose responsibility is to 1) implement state policy for children and adolescents with emotional disabilities, 2) resolve local problems in meeting the needs of these youths, and 3) monitor the state's wraparound service programs. The State Interagency team includes representatives of education, mental health and mental retardation, and social rehabilitation services agencies, along with one parent representative.

PROGRAM/SERVICES

New Directions has developed statewide community-based services to reduce out-of-state placements. Vermont offers a balance of regional services and individualized care. The state has expanded the concept of therapeutic case management to include both treatment planning and financial planning; each of the state's 12 counties has a therapeutic case manager, who is responsible for both the treatment plan and the financial plan to support treatment.

When a youth is referred to the therapeutic case management program, a case manager convenes a meeting of the treatment team, comprised of representatives of mental health, social service, and education, the youth (depending upon age and maturity), his parents, and other individuals of importance in the youth's life. This team develops a plan based on a thorough assessment of a broad range of life dimensions: residential, therapeutic/behavioral, educational/vocational, social/recreational, medical/psychiatric, safety/crisis plan, legal, and other. Strengths of the youth are discussed to balance the identification of his problems and needs.

Once the service plan has been developed, the therapeutic case manager purchases and coordinates the delivery of appropriate services and advocates on the youth's behalf across service systems. Case managers carry the responsibility of making sure that service plans are developed, implemented, and reviewed on an ongoing basis. With caseloads ranging from 4 to 12, therapeutic case managers spend an average of 7 to 10 hours weekly working with each family in three areas: advocacy, coordination, and education. Case managers are also involved in assessment, planning, linking services, monitoring, and evaluation.

A special focus of the Vermont program is on crisis stabilization and respite. This emphasis recognizes that a youth who has an emotional disability is likely to experience periodic crises. As part of the treatment planning process, the type of crisis most likely to occur is anticipated and a response plan is developed in advance that specifies how the treatment team and the family will react. Similarly, the need for respite for both the youth and his family is anticipated, and plans are developed that allow the youth and/or his parents to have a break from one another.

The Vermont system of care relies on a strong system of care that provides several vital components in each service area of the state. These services include intensive home-based services, therapeutic foster care, crisis stabilization, special education, intensive residential treatment, parent support groups, supervised independent living, community residential treatment, and respite care.

Community-based programs. Start-up funding has been provided by New Directions for several community-based efforts in the state. One of these, the Rutland Central Supervisory Union's program, focuses on serving individuals and their families in their home communities. Students are fully integrated into regular classrooms. With the twin goals of prevention and success, the project focuses on the "development of a positive self-concept, competent interpersonal skills, and civic responsibility as a whole and healthy child: socially, emotionally, and academically" (Boltax, Thomas & Nasta, 1993, p. 5). Supports such as ongoing psychological counseling in school and at home, behavior management, in-class support for students and teachers, and group therapy help attain these goals. A home/school coordinator serves as a liaison between students, families, and community-based human service agencies and offers parent education. Community experiences, career awareness, and outdoor activities are also part of the program.

Training. New Directions offers a 12-month training program for staff members from all involved agencies. Professional mentoring on clinical and administrative issues is provided to new programs and new therapeutic case managers.

FUNDING

Since Vermont has not created a method to pool monies to provide flexible funding for individualized service plans, the state relies upon existing state and federal funding streams to support services. According to program literature, "The use of current funding streams links the wraparound program to the rest of the service system, making it easier to apply individualized service concepts across the entire system of care." The state departments of Mental Health/Mental Retardation, Social and Rehabilitation Services, and Education have successfully collaborated to maximize federal Medicaid matching dollars. Funds previously spent on out-of-state care and general funds spent within the state are now being used to leverage more federal dollars. The state has used a variety of federal and foundation grants and is one of eight recipients of a grant from the Robert Wood Johnson Foundation's Mental Health Services Program for Youth.

EVALUATION

New Directions has significantly reduced out-of-state placements of youth and has reallocated those funds to provide community-based services for a greater number of youths. The project has also succeeded in decreasing the number of students in segregated school and classroom settings while increasing the inclusion of students in regular education programs. Additionally, a decrease in the frequency of severe negative behaviors, including physical aggression, property damage, running away, sexual assault, and self-injury has been noted after one year's participation in the program (Goldman, 1992).

ADDITIONAL INFORMATION

A profile of the project is included in *Partnerships for Care: Systems of Care for Children with Serious Emotional Disturbances and Their Families.*

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NATIONAL AGENDA FOR ACHIEVING BETTER RESULTS FOR CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE

Prepared by the
Chesapeake Institute
for the
U.S. Department of Education
Office of Special Education and Rehabilitative Services
Office of Special Education Programs

May 12, 1994

105

NATIONAL AGENDA FOR ACHIEVING BETTER RESULTS FOR CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE

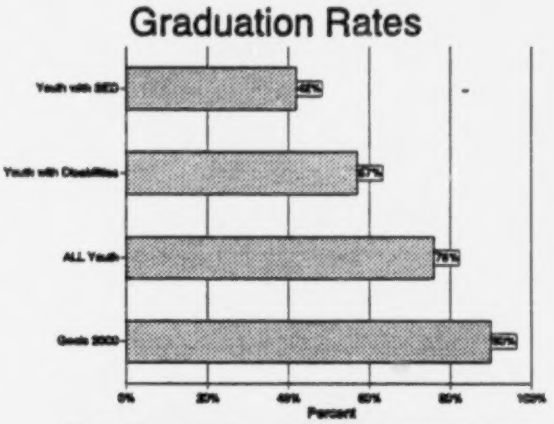
The Problem

Effectively serving and meeting the needs of children and youth with serious emotional disturbance (SED) and their families is a national concern. The necessity of addressing the needs of these children and youth has become increasingly apparent. Failure to do so threatens the success of the nation's educational objectives (e.g., GOALS 2000) and limits life-long opportunities for many individuals. The following data suggest the magnitude of the problem:

- Academic Outcomes. Students with SED have lower grades than any other group of students with disabilities. They fail more courses and they more frequently fail minimum competency examinations than do other students with disabilities; they also are retained at grade level more often at the end of the school year. High school students with SED have an average grade point average of 1.7 (on a four-point scale), compared to 2.0 for all students with disabilities and 2.6 for all students. Forty-four percent received one or more failing grades in their most recent school year (compared to 31 percent for all students with disabilities). Of those who took minimum competency tests (22 percent were exempted), 63 percent failed some part of the test.

- Graduation Rates. Forty-two percent of youth with SED earn a high school diploma, as opposed to 57 percent of all youth with disabilities and 76 percent of similarly aged youth in the general population.

- School Placement. Eighteen percent of students with SED are educated

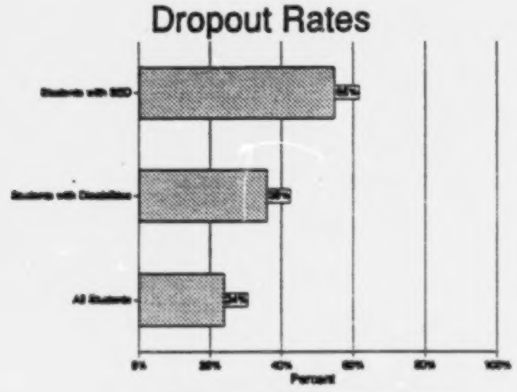


SOURCE: Youth with Disabilities: How are They Doing: The First Comprehensive Report from the National Longitudinal Transition Study of Special Education Students.

outside of their local schools, compared to 6 percent of all students without disabilities. Of those in their local schools, fewer than 17 percent are educated in regular classrooms, in contrast to 33 percent of all students with disabilities.

- School Absenteeism. Students with SED miss more days of school per year (an average of 18 days) than do students in any other disability category.

- Dropout Rates. Fifty-five percent of students with SED drop out of school, as opposed to 36 percent of students with disabilities and 24 percent of all students.



SOURCE: National Longitudinal Transition Study of Special Education Students.

- Encounters with the Juvenile Justice System. Twenty percent of students with SED are arrested at least once before they leave school. Of those students with SED who drop out, 74 percent are arrested within five years of leaving school.

- Identification Rates of Students of Varying Socio-Economic Backgrounds. The rates of identification of children and youth with SED vary across racial, cultural, gender, and socioeconomic lines. Although African-American and white students represent 16 and 68 percent of the school age enrollment respectively, they represent 22 and 71 percent of the students classified as SED. On the other hand, Hispanic-Americans and Asian-Americans represent 12 and 3 percent of the school-aged population respectively, but only 6 and 1 percent of the students classified as SED. Data also suggest that students from low-socioeconomic backgrounds are over-represented and female students underrepresented among those identified with serious emotional disturbance.

Compared to all students with disabilities: (1) students with SED are more likely to be placed in restrictive settings and are more likely to drop out of school; (2) their families are more likely to be blamed for the student's disability and are more likely to make tremendous financial sacrifices to secure services for their children; and (3) their teachers and aides are more likely to seek reassignment or leave their positions.

The Legislative and Administrative Background

In 1990, Congress authorized a new program for children and youth with SED under Part C of the Individuals with Disabilities Education Act (IDEA). IDEA mandates provision of a "free appropriate public education" (FAPE) for children with disabilities. IDEA also mandated a participatory planning process, involving multiple stakeholders in the development of program goals, objectives, strategies, and priorities for all programs administered by the Office of Special Education Programs (OSEP), including the new program for children and youth with SED.

In order to help frame and guide the planning process, OSEP defined its mission as "Achieving Better Results for Individuals with Disabilities," and identified four initial goals to achieve that mission. These goals were:

- To provide and maintain an adequate number of qualified personnel;
- To develop the capacity to ready systems to meet the needs of changing populations;
- To secure and expand access and inclusion for children with disabilities; and
- To identify measures and improve outcomes for individuals with disabilities.

OSEP's Division of Innovation and Development (DID), which administers the SED program, also developed mission and vision statements to guide programs for students with SED. The Mission is: *Achieving better results for students with serious emotional disturbance*. The Vision is: *A reorientation and national preparedness to foster the emotional development and adjustment of all children and youth, including those with serious emotional disturbance, as the critical foundation for realizing their potential at school, work, and in the community.*

OSEP used the initial goals, mission and vision statements to implement a strategic planning process that had three objectives: (1) to develop a national agenda that would focus the attention of educators, parents, advocates, and professionals from a variety of disciplines on what must be done to encourage, assist, and support our nation's schools in their efforts to achieve better outcomes for children and youth with serious emotional disturbance; (2) to provide recommendations for DID initiatives and funding opportunities aimed at providing better outcomes for children and youth with SED; and (3) to provide background for the

IDEA-authorized program for children and youth with SED. This planning process incorporated one-on-one interviews, literature reviews, focus groups, stakeholder meetings, an interactive national teleconference, presentations, and the solicitation of oral and written responses.

Strategic Targets and Cross-Cutting Themes

Significantly improving results for children and youth with SED requires a vision of transformed service systems, reoriented professional attitudes, and an emphasis on positive outcomes. Toward these ends, OSEP and the participants in the planning process identified the following seven interdependent strategic targets:

THE STRATEGIC TARGETS

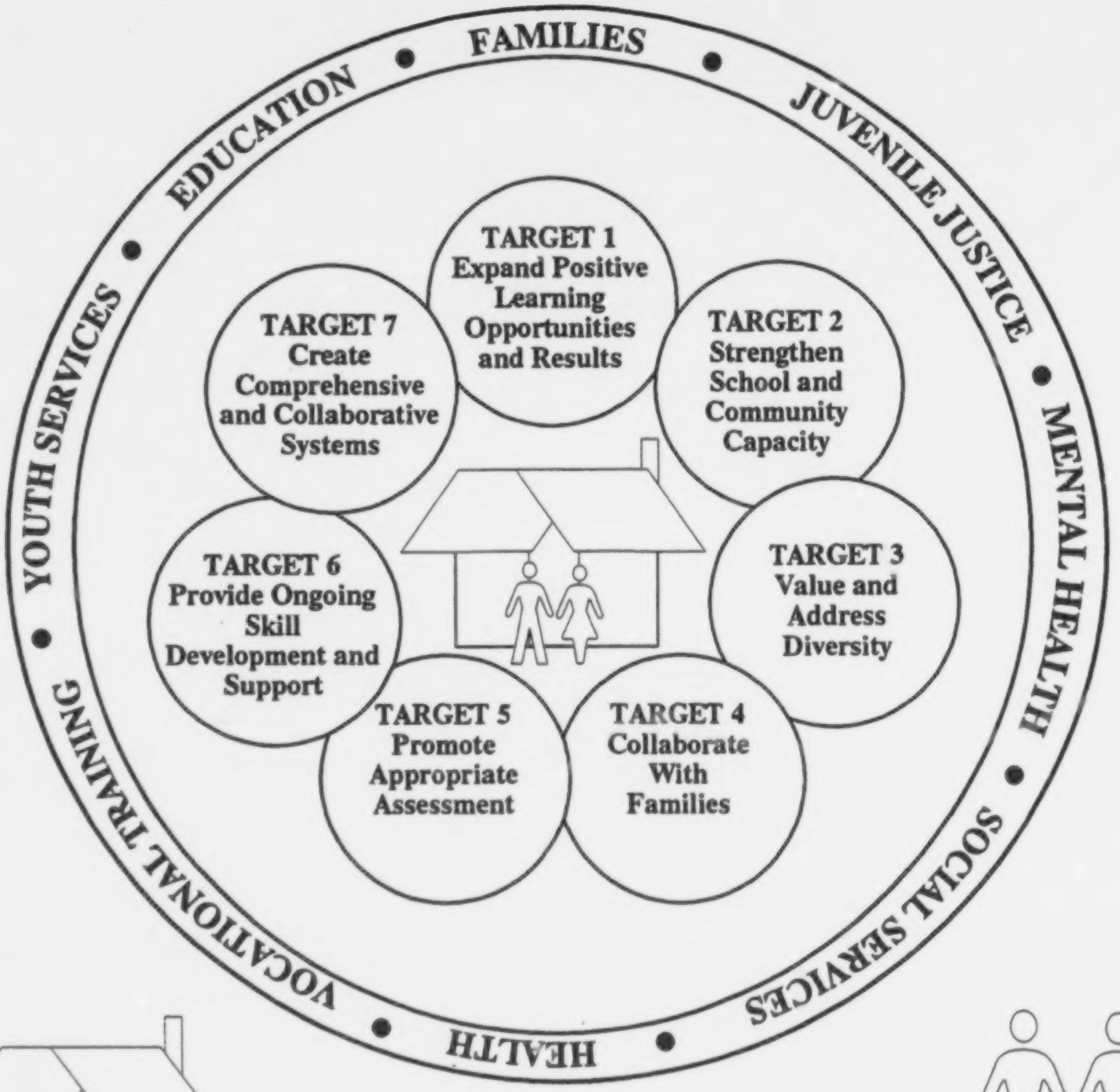
- ✓ *Expand Positive Learning Opportunities and Results*
- ✓ *Strengthen School and Community Capacity*
- ✓ *Value and Address Diversity*
- ✓ *Collaborate with Families*
- ✓ *Promote Appropriate Assessment*
- ✓ *Provide Ongoing Skill Development and Support*
- ✓ *Create Comprehensive and Collaborative Systems*

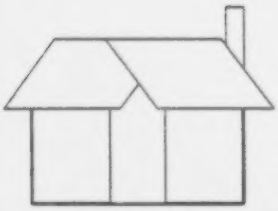
Underlying the seven targets are several key assumptions that embody an understanding that a flexible and proactive continuum of services must be built around the needs of children with SED and their families. Furthermore, services must not only be available, but must be sustained and comprehensive, and must collaboratively engage families, service providers, and children and youth with serious emotional disturbance. Finally, both the needs of these children and increasing demographic diversity of our nation call for cross-agency, school- and community-based relationships that are characterized by mutual respect and accountability — with the child always in focus. Accordingly, OSEP identified the following three cross-cutting themes that reflect this understanding:

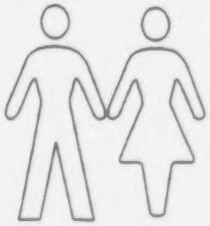
- Collaborative efforts must extend to initiatives *that prevent* emotional and behavioral problems from developing or escalating;
- Services must be provided in a *culturally sensitive and respectful* manner; and
- Services must *empower* all stakeholders and maintain a climate of possibility and accountability.

The strategic targets developed for the national agenda for children and youth with serious emotional disturbance are linked. Each target can be best understood and implemented in concert with the other targets and in the context of a collaborative process, as is suggested in Figure 1, "National Reorientation and Preparedness to Achieve Better Results." Achieving successful outcomes for children and youth with SED depends on pursuing and attaining all of the targets listed in Figure 2.

REORIENTATION AND PREPAREDNESS TO ACHIEVE BETTER RESULTS


FAMILIES
JUVENILE JUSTICE
MENTAL HEALTH
SOCIAL SERVICES
HEALTH
VOCATIONAL TRAINING
YOUTH SERVICES
EDUCATION
TARGET 1 Expand Positive Learning Opportunities and Results
TARGET 2 Strengthen School and Community Capacity
TARGET 3 Value and Address Diversity
TARGET 4 Collaborate With Families
TARGET 5 Promote Appropriate Assessment
TARGET 6 Provide Ongoing Skill Development and Support
TARGET 7 Create Comprehensive and Collaborative Systems





SCHOOL AND COMMUNITY RESULTS
- Community Strength
- Family Preservation
- Fiscal Efficiency
- Teacher Retention
- School Effectiveness

STUDENT RESULTS
- Improved Grades
- Enhanced Learning
- Higher Graduation Rates
- Increased Equity
- Successful Transition to Adult Roles

COLLABORATE → IMPLEMENT TARGETS → ACHIEVE RESULTS

FIGURE 2

NATIONAL AGENDA FOR ACHIEVING BETTER RESULTS FOR CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE

TARGET #1: EXPAND POSITIVE LEARNING OPPORTUNITIES AND RESULTS

To foster the provision of engaging, useful, and positive learning opportunities. These opportunities should be result-driven and should acknowledge as well as respond to the experiences and needs of children and youth with serious emotional disturbance.

TARGET #2: STRENGTHEN SCHOOL AND COMMUNITY CAPACITY

To foster initiatives that strengthen the capacity of schools and communities to serve students with serious emotional disturbance in the least restrictive environments appropriate.

TARGET #3: VALUE AND ADDRESS DIVERSITY

To encourage culturally competent and linguistically appropriate exchanges and collaborations among families, professionals, students, and communities. These collaborations should foster equitable outcomes for all students and result in the identification and provision of services that are responsive to issues of race, culture, gender, and social and economic status.

TARGET #4: COLLABORATE WITH FAMILIES

To foster collaborations that fully include family members on the team of service providers that implements family focused services to improve educational outcomes. Services should be open, helpful, culturally competent, accessible to families, and school- as well as community-based.

TARGET #5: PROMOTE APPROPRIATE ASSESSMENT

To promote practices ensuring that assessment is integral to the identification, design, and delivery of services for children and youth with SED. These practices should be culturally appropriate, ethical, and functional.

TARGET #6: PROVIDE ONGOING SKILL DEVELOPMENT AND SUPPORT

To foster the enhancement of knowledge, understanding, and sensitivity among all who work with children and youth with and at risk of developing serious emotional disturbance. Support and development should be ongoing and aim at strengthening the capacity of families, teachers, service providers, and other stakeholders to collaborate, persevere, and improve outcomes for children and youth with SED.

TARGET #7: CREATE COMPREHENSIVE AND COLLABORATIVE SYSTEMS

To promote systems change resulting in the development of coherent services built around the individual needs of children and youth with and at risk of developing serious emotional disturbance. These services should be family-centered, community-based, and appropriately funded.

STRATEGIC TARGET 1: EXPAND POSITIVE LEARNING OPPORTUNITIES AND RESULTS

To foster the provision of engaging, useful, and positive learning opportunities. These opportunities should be result-driven and should acknowledge as well as respond to the experiences and needs of children and youth with serious emotional disturbance.

The poor outcomes achieved by students with serious emotional disturbance cannot be successfully addressed by focusing on these students alone. Their poor success rates and frequent removal from mainstream classes and regular schools reflect school and community factors, as well as the nature of their emotional needs. Often student behavior escalates out of control and academic failure occurs before schools intervene. Intervention is often limited to external control, with little attention given to internal development of self-control, self-management, self-advocacy, and conflict resolution skills.

Students with SED must be engaged in culturally responsive, student-centered opportunities to learn, marked by high expectations and tailored to their individual needs. Curricula, instruction, and extra-curricular activities must build academic and social skills that enable students to sustain appropriate learning and behavior. School- and community-based learning must be better coordinated so that these students acquire and maintain the academic and social skills which will make them literate, productive, and responsible members of their communities.

This target supports coordinated initiatives that improve the effectiveness of teachers, families, schools, and other agencies to teach and contribute to the academic, social, and emotional development of students with SED and those at risk for developing SED. These students should have access to challenging curricula, effective teaching, and robust learning experiences that enhance their academic, vocational, and social skills. Proactive approaches emphasize prevention, early intervention, and learner-centeredness. Collaborative learning environments respond to the needs of all students, teach both academic and social skills, and build on each student's strengths and interests. The target calls for providing opportunities for success that will enable students with SED to develop the knowledge, skills, and attitudes essential for educational, social, and workplace achievement.

STRATEGIC TARGET 2:
STRENGTHEN SCHOOL AND COMMUNITY CAPACITY

To foster initiatives that strengthen the capacity of schools and communities to serve students with serious emotional disturbance in the least restrictive environments appropriate.

Students with behavioral problems and serious emotional disturbance are often removed from regular schools and general education settings. Their removal reflects many factors, including the current school environment and the need to provide complex and comprehensive services across many service delivery systems. Placements made out of neighborhood schools and communities are often very costly to communities and disruptive to families. In addition, these placements may prevent many students from developing the academic and social competencies they require to use throughout their lives.

This target calls for serving children and youth with SED in the least restrictive and most appropriate environments. In particular, and as far as possible, it means developing the capacity to successfully integrate these students into neighborhood schools and regular classrooms. To make integration and transitions work, students with SED and the teachers who work with them require support and resources. Educational systems must be prepared to facilitate integration and smooth the transition of students back into their own homes, schools, and communities.

This strategic target calls for the development and the expansion of initiatives that improve the readiness and capacity of general education settings to educate and provide needed services to students with SED. This target supports early intervention, prevention, and pre-referral initiatives such as early screening, teacher consultation, and mainstream assistance teams. It supports active collaborations among regular and special educators, service providers, and families that enable these students to learn and participate in activities with their peers. Existing initiatives that address these goals include: providing field-based training to regular educators; using special educators as consultants; reducing teacher-student ratios; implementing non-traditional methods of dispute resolution; adopting approaches to discipline that keep students in class; teaming special educators in classrooms with regular educators; and bringing mental health specialists into schools.

STRATEGIC TARGET 3: VALUE AND ADDRESS DIVERSITY

To encourage culturally competent and linguistically appropriate exchanges and collaborations among families, professionals, students, and communities. These collaborations should foster equitable outcomes for all students and result in the identification and provision of services that are responsive to issues of race, culture, gender, and social and economic status.

The rates of identification, placement, and achievement of children and youth with emotional and behavioral problems vary across racial, cultural, gender, and socioeconomic dimensions. Incomplete understanding of differences can lead to the misidentification and inappropriate treatment of children. To avoid misidentification and inappropriate treatment, diversity must be addressed and valued. To value diversity is to acknowledge, understand, and appreciate the characteristics of different cultures and different groups of people. To address diversity is to develop the ability to work successfully with people of diverse backgrounds when designing and implementing services for children with serious emotional disturbance.

This target calls for approaches that improve the capacity of individuals and systems to respond skillfully, respectfully, and effectively to students, families, teachers, and other providers in a manner that recognizes, affirms, and values their worth and dignity. To accomplish this, the target supports collaborations among families, professionals, students, and communities that identify and provide what are defined as culturally competent services to address the needs of children and youth with serious emotional disturbance.

Cultural competencies describe the interpersonal skills and attitudes that enable individuals to increase their understanding and appreciation of the rich and fluid nature of culture and of differences and similarities within, among, and between cultures and individuals. Furthermore, cultural competency is not merely a set of tools learned at one point in time and applied over and over again. Rather, it is a process that educators and other service providers must learn to adapt to each new individual encounter.

Culturally competent approaches recognize the cultural grounding of teachers' and service providers' views, behaviors, and methods. These approaches also recognize the power of language and attend to the communicative styles of students and their families. Culturally competent approaches address culturally based definitions of family and networks. They view family and community as critical parts of a student's support system. Such approaches also demonstrate a willingness and ability to draw on community-based values, traditions, customs, and resources. Pre-referral and preventive approaches that are culturally competent and linguistically appropriate recognize and nurture the strengths — individual and cultural — that students bring to school.

STRATEGIC TARGET 4: COLLABORATE WITH FAMILIES

To foster collaborations that fully include family members on the team of service providers that implements family focused services to improve educational outcomes. Services should be open, helpful, culturally competent, accessible to families, and school- as well as community-based.

Families represent a child's most intimate support system, and yet familial support and participation in service systems have historically not been a priority. In fact, families have often been held responsible for their children's problems. Today, families of children and youth with SED often serve as their children's advocates and case managers, negotiating between and among the education, health, mental health, substance abuse, welfare, youth services, and correctional systems.

Family support services are frequently a key factor in successfully addressing the needs of children and youth with SED. The degree of family support is especially related to the success of least restrictive placements, as success may depend upon a family's ability to obtain the educational, mental health, and other services required to maintain a child in the home. Training that enables family members to advocate effectively for these students is also an important element in successful placement of students with SED. To improve outcomes for these children and youth, service providers must collaborate with families and support the active participation of families in planning and evaluation.

Collaborating with families and strengthening their access to required services is central to realizing the goal of implementing appropriate, integrated services across education, mental health, and other systems. Service providers should seek and facilitate active parental involvement when planning assessments and when determining what services to provide. The object of this strategic target is to reorient family-school interactions to build a partnership in which service planning reflects the input of families' goals, knowledge, culture, and, in some cases, need for additional services.

Any collaborative relationship should be marked by a demonstration of respect and compassion for family members; an understanding and an accommodation of different styles of social interaction; the use of straightforward language; creative outreach efforts; respect for families' cultures and experiences; providing families with crucial information and viable options; and the scheduling of IEP meetings at convenient times and places for families, care givers, and surrogates. In addition, families may need respite care and day care to meet the needs of their other children. Necessary services may also include counseling, training, support groups, and immediate crisis intervention to enable families to work and live with children and youth with SED.

Examples of family-responsive services include: (1) designating a single person to coordinate services for the family; (2) establishing single point of entry intake procedures for all services; (3) staffing technical assistance centers with family members; (4) expanding the role of families and care givers at IEP meetings and placing a family report on the agenda for the meetings; and (5) including families in outreach planning and cultural competency training.

STRATEGIC TARGET 5: PROMOTE APPROPRIATE ASSESSMENT

To promote practices ensuring that assessment is integral to the identification, design, and delivery of services for children and youth with SED. These practices should be culturally appropriate, ethical, and functional.

Appropriate, ongoing, cost-effective, and practical assessment is essential to improving outcomes for children and youth with serious emotional disturbance. Screening, monitoring, and assessment can identify children at risk, support preventive interventions that may reduce the need for formal identification at a later time, augment planning, and monitor the implementation of comprehensive services. Culturally competent, linguistically appropriate, multi-disciplinary assessments that involve families can help teachers build on student strengths and address the changing developmental needs of students with SED. Ongoing assessments that focus on the student's environment (including the school) can enable teachers and service providers to prevent emotional problems from intensifying, thus avoiding the need for more protracted and expensive interventions in the future.

The efficacy of service depends upon ongoing and continuous assessment that best captures a child's changing developmental needs. This target supports initiatives that provide for early identification and assessment tied to services rather than to labels. Identification and assessment frequently come too late and lead to the inappropriate placement, labelling, and treatment of students with emotional and behavioral problems.

This target addresses concerns that current assessments fail to identify the support and modifications necessary for the successful integration or re-integration of students with SED into regular education settings. The target supports the early screening and identification of children with emotional or behavioral problems by a multidisciplinary team of professionals and parents so that these children's problems are addressed before a cycle of failure, truancy, dropping out, and delinquency is established. This target supports practical and timely assessments that enable teachers and schools to use appropriate strategies and to assure that interventions are producing desired results.

Further, this target encourages the development of sensitive identification and assessment procedures to meet the needs of all children and prevent the exacerbation of emotional and behavioral problems. These procedures should be accurate, linguistically appropriate, and culturally fair and should provide necessary information to enable educators to provide appropriate educational experiences for all students with emotional and behavioral disorders. The target supports initiatives that use culturally appropriate and functional assessment data to strengthen the capacity of general education teachers and schools to effectively integrate and teach students with emotional and behavioral problems.

STRATEGIC TARGET 6: PROVIDE ONGOING SKILL DEVELOPMENT AND SUPPORT

To foster the enhancement of knowledge, understanding, and sensitivity among all who work with children and youth with and at risk of developing serious emotional disturbance. Support and development should be ongoing and aim at strengthening the capacity of families, teachers, service providers, and other stakeholders to collaborate, persevere, and improve outcomes for children and youth with SED.

Improving outcomes for students with SED will require new skills, approaches, and collaborations among all who work with these children and youth. Teachers and professionals frequently report feeling isolated and unsupported by colleagues and families. In addition, the need for comprehensive services coupled with the complex nature of serious emotional disturbance may create a gap between what is learned in teacher training programs and what teachers face in the classroom and in the school. Special and general educators as well as other service providers also require ongoing skill development and training that will enable them to work effectively with one another.

This strategic target provides for the ongoing support and professional development of teachers and other service providers in order to: (1) increase their capacity to teach and work effectively, (2) reduce their sense of isolation, and (3) enhance their commitment to meeting the needs of students with SED. Professional development for teachers and other service providers should extend to families in some cases so that all those working with children with SED can develop new skills, acquire knowledge of promising intervention techniques, and become aware of new innovations and practices.

An example of one strategy likely to support attainment of this target is that of field-based workshops promoting collaboration among families, teachers, aides, administrators, and mental health professionals. Well-managed workshops give participants the opportunity to share information and experiences regarding the diversity, the complexity of needs, and the potential for learning and growth of students with SED. Additionally, strategies that foster collaboration among teachers, families, and service providers can be effective pre-referral, early identification, and prevention tools. Other strategies may include mentoring, subsidized training time, and ongoing field-based training and consultation.

The implementation of this target will provide support for the other strategic targets, particularly those calling for collaborative relationships and culturally sensitive and competent services. It also will support the reorientation of professional roles and a preparedness to effectively serve children and youth with SED; and it will foster the development of attitudes and skills that are congruent with improved opportunities and outcomes for all children and youth with SED. Finally, achieving this target will provide ongoing support and professional development for teachers and other professionals, thus reducing their sense of isolation and fostering their commitment and persistence in meeting the challenging needs of the children and youth whom they serve.

STRATEGIC TARGET 7: CREATE COMPREHENSIVE AND COLLABORATIVE SYSTEMS

To promote systems change resulting in the development of coherent services built around the individual needs of children and youth with and at risk of developing serious emotional disturbance. These services should be family-centered, community-based, and appropriately funded.

As many children and youth with serious emotional disturbance and their families attempt to maneuver through a fragmented, confusing, and overlapping aggregation of services in education, mental health, health, substance abuse, welfare, youth services, correctional, and vocational agencies, they encounter and must endure competing definitions, regulations, and jurisdictions in a delivery system marked by formalism, categorical funding, and regulatory road blocks. To effectively plan, administer, finance, and deliver the necessary educational, mental health, social, and other support services to students and their families, coordination among the numerous agencies involved must increase and improve.

Systemic change is needed to enhance regional and community capacity to the point where those involved can meet all of the needs of children and youth with SED. Simultaneously, systems must be developed that can bring services into the child's environment, whether it be the home, school, or community. Furthermore, to achieve the desired outcomes for children and youth with SED, public and private funding streams must be coordinated.

This strategic target supports initiatives to help generate comprehensive and seamless systems of appropriate, culturally competent, mutually reinforcing services. This target envisions systems that are more than linkages of agencies. It aims instead at developing new systems, built around the needs of students, families, and communities — systems that coordinate services, articulate responsibility, and provide system-wide and agency-level accountability.

Local systems should remain school- and community-based so that they can respond to local needs and reflect the cultures of the communities they serve. Systems should be outcome oriented, employ uniform definitions, provide individualized and family-centered services, and respond promptly, flexibly, and effectively during any crisis. Within a coordinated, collaborative system, services follow needs, and funds follow children and their families. Students and their families should be able to enter the entire system from any point at which specific services are first offered. Finally, while the new systems should be community-based, policy must be coordinated at the state and national levels. Such coordination will eliminate bureaucratic road blocks, establish and reinforce commitment among agencies, and extend initiatives that coordinate previously non- or unaligned services and blend funding streams, both public and private.

Promising approaches toward systems development have addressed the need to nurture collaboration, innovation, and an outcome-oriented approach to planning and decision making. Some initiatives have done so successfully by involving children, teachers, and advocates in planning and evaluating new systems. Other efforts have provided policy makers with an opportunity for hands-on decision making regarding specific students so that they can understand the need to blend services and funding. Still other promising approaches provide common training and workshops to families, educators, human service workers, administrators, board members, and advocates in order to support collaboration, nourish transdisciplinary orientations, and sustain local networks.

Appendix B
Cities in Schools

Burchard, J. D., Burchard, S. N., Sewell, R., and VanDenBerg, J. (1993). *One kid at a time: Evaluative case studies and description of the Alaska Youth Initiative Demonstration Project*. Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

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ONE KID AT A TIME

Evaluative Case Studies and Description

of the

Alaska Youth Initiative Demonstration Project

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What AYI services and policies were most commonly associated with successful outcomes?

The key features and characteristics identified as being most critical to the success of AYI by the individuals interviewed and by analyses of the 10 case studies are as follows:

Overall AYI philosophy. Almost everyone interviewed spoke about the importance of the overall AYI philosophy. In general, they were referring to the unconditional commitment to a tough child or youth, the interdisciplinary teamwork, the commitment to least-restrictive, community-based services, the flexible funding and flexible services, and the individualized and child-focused treatment plans. It was clear that this philosophy was substantially different from "business as usual" in service delivery and it generated a high degree of enthusiasm and morale.

Individualization of planning and service delivery. An essential component of the success of AYI was fitting the services to the youth rather than trying to fit the youth to a program. Creative examples of this include placing a youth in a 24-hour-staffed apartment rather than in a group home, providing a paid friend for social integration, having a youth live in an apartment with an admired mentor or peer, and having a youth live with a young couple and their child in order to learn parenting skills.

Unconditional commitment to the child. The best youth outcomes were associated with providers whose attitudes reflected unconditional care, "no matter what the kid does." In general, staff stayed with the youth, retrieved the youth, negotiated with the youth, and stood up for the youth through the most difficult times. Through this process, they developed mutual, trusting relationships which helped to minimize the multiple placement shuffle. Staff refused to give up.

Multidisciplinary teamwork. Core Services Teams, typically comprised of the youth, parent(s), service providers, and key agency representatives from mental health, education, and social services, made decisions on the basis of consensus and shared responsibility. Although the size and constituency of treatment teams varied considerably, successful outcomes were highly related to effective teamwork and coordination, in some cases, in a dramatic fashion.

Flexible funding. AYI had the ability to energize services and systems with flexible funds which "followed the youth." The Core Services Teams were able to use flexible funds to add critical resources in a timely manner, frequently preventing a transition into a more restrictive service. These included such resources as a temporary one-on-one aide in a school or residential setting to assist with a crisis, transportation to maintain continuity in school during a change in residence, tuition for summer camp, and emergency respite for a caretaker.

Staff skilled in promoting youth trust and respect. In several cases, there was dramatic improvement in a youth's attitude and behavior, exemplified by a sharp reduction in the number of placements, AWOLs, and crisis episodes. These changes were clearly associated with the development of a strong bond between the youth and a provider. These providers (e.g., a foster parent, an aide, a group home parent) were strong advocates for the youth, skillfully listened to their concerns, and stuck with them through some very difficult times.

Excellence of direct care personnel. The key factor in youth recovery often was the quality of direct-care staff. AYI was frequently able to recruit excellent personnel who were experienced and/or were well trained in working with challenging, disturbed youth; they could provide structure and consistency while also being flexible and drawing on the youth's strengths and interests.

Structured behavioral contingencies. In most cases, some form of behavioral contracting or contingency management was in place at home, and often at school, assisting the youth in developing self-control and a more respectful relationship with providers. Providing structure and limits that required responsible behavior and opportunities for restitution were related to successful outcomes, particularly when these factors were perceived as fair by the youth.

Community-based services. Almost all of the AYI services were provided in settings in the community that were less restrictive than long-term residential care. This provided the youth with the greatest opportunity to learn the skills that are essential for autonomy and self-sufficiency. By learning to control their behavior and achieve success in more natural settings, youth are more likely to cope with the inevitable conflicts that will arise after services are removed.

Developing crisis plans. Over time, AYI became very creative and adept at developing crisis plans that made it possible to avoid placing the child in a secure facility. In general, this involved the timely addition of trained personnel to defuse, or at least stabilize, a situation. AYI was less successful in implementing a crisis response that required the participation of another agency (see below).

What might improve the AYI service or improve an individualized, wraparound delivery system?

Increase training. Much of the training that took place for the parents, administrators, advocates, and service providers in these 10 cases could be characterized as fragmented, crisis-promoted, on-the-job training. This is understandable given that AYI had to invent much of the wheel in this effort to serve the most difficult youth in their communities and villages. Clearly, any replication of the AYI program would be rendered more effective through a more prolonged and proactive training program that incorporated the learnings of AYI.

Begin AYI services sooner. The findings in this study strongly imply that even greater progress could have been made if AYI services had begun earlier in a youth's life. In the opinion of several people who were interviewed, AYI services should begin at the point where long-term residential care is being considered. There is little indication that any progress made was facilitated by long-term residential care, either in state or out of state. This opinion was shared by all but one youth, all parents, and almost all providers. A substantial number of people interviewed felt that the long-term residential treatments that took place were actually harmful. Even in those cases where residential treatment appeared to produce no effect, there was concern that it consumed time during which progress could have been made through individualized services.

With respect to starting sooner, it is necessary to establish clear criteria for inclusion. There is ample justification for including any youth for whom existing or anticipated costs are equal to, or exceed, the costs of individualized services. But when starting sooner means a significant increase in the cost of services, it is necessary to try to target those youth who would otherwise receive more costly services. It is unlikely that any service delivery system will be able to afford a relatively major investment at both ends of the continuum of services. Given the struggle to obtain new resources in the area of human services, it is more practical to try to shift the way resources are spent than to add new ones.

In addition to starting AYI services at the point that a sustained residential placement is being considered, AYI should be viewed as a way to stop frequent changes in placement. While some placement change is inevitable, extraordinary efforts should be made to prevent repeated placements similar to the dozens of placements that occurred prior to AYI in many of the cases that were reviewed.

Develop a more controlled and flexible crisis response. Some AYI service providers spoke of having inadequate resources to respond in a timely fashion to infrequent but extreme escalations in aggression towards self or others. The typical response was to call the state police and/or to try to have the youth admitted to the state hospital or correctional center, depending on the incident. On several occasions, the police did not respond in a timely fashion because the incident did not involve a potential felony (e.g., a smashed door or wall). The problems with the residential placements were an inability to meet admission criteria, particularly in a timely fashion, or, once admitted, an inability to influence discharge, resulting in an unnecessarily long stay.

The service providers in question appeared to be seeking a crisis response that would safely stabilize the youth (with their participation), and would enable them to return the youth to the AYI residence in order to work through the problems that precipitated the crisis. On at least two occasions, the state hospital functioned very successfully in that capacity. Any cooperative agreements which would facilitate that type of crisis response would be helpful.

Wherever the need, continue AYI services into adulthood. While it is apparent that some youth could have benefitted from an earlier admission into AYI, it is also clear that many youth will need some services well into adulthood. Given the progress that has been made, it will be unfortunate if these youth regress because adult services are fragmented, inadequate, or unavailable.

Avoid grouping multineed youth. For several of the youth receiving AYI services, there were occasions when they were placed with other multi-need youth. This happened most during times when AYI was recruiting specialized foster parents or when there was a need to stabilize a youth following a crisis. In most of these cases, it did not appear that the group component facilitated progress and, in some instances, it was clear that such placement served as a barrier. While it may be less expensive to group youth together, in the long run it may be less cost effective. More emphasis needs to be placed on the utilization of non-multineed peers.

Establish financial security for direct care staff. A common concern among the direct care staff (e.g., foster parents, professional roommates, mentors, apartment supervisors) was financial security and long-term benefits. In general, they loved their work. They had more control, flexibility, and support than existed in the categorical service delivery system. They also received higher salaries. But they tended not to have much long-term security. As one worker put it, "It's great while it lasts, but as the youth makes progress, you can work yourself out of a job." Many excellent direct care staff were interviewed during this study. They might function even better if they knew that unconditional care also applied to them.

Other recommendations. Finally, a number of recommendations were mentioned less frequently. They included collecting more timely outcome data to facilitate adjustments in services, increasing participation of the youth themselves in the development and modification of their service plans, and increasing communication with the primary parent or relative, especially when she or he is located a significant distance from the youth.

Conclusions

In general, there are two striking findings in this qualitative evaluation of the Alaska Youth Initiative. One is that remarkable changes took place in 9 out of the 10 youth who were studied; the other is the radical difference in the way the youth in this study were served.

With respect to the progress of these youth, eight were now young adults living in the community. All but one were living fairly independently, having gained significantly in self-respect and self-confidence in their personal future. In addition, they had gained personal empowerment. They had acquired many skills: skills in daily living, skills in self-control, some educational and work-related skills, skills for finding and using assistance from social programs, and skills in accessing community resources. Those with serious drug dependencies appeared to have broken their drug habits. They also had built the beginnings of meaningful social support networks.

The two youngest of the 10 remained in specialized foster homes, also having gained enormously in self-control, self-respect, and social skills. Both of these young people had access to activities and opportunities within the mainstream culture that would enable them to learn and acquire needed skills, including basic academics, which may eventually empower them to succeed as adults.

With respect to the service model, it clearly differed from "business as usual." Given that most of the youth in this study had behaved their way out of the least restrictive, and in some cases the most restrictive services that were available, an anticipated response could have been that more isolation, more restriction, and more medication were called for. Instead, these youth were moved into the community and, with a striking amount of commitment, creativity, and ingenuity, services were administered on the basis of their individual needs.

The critical question as to whether or not the service model caused the remarkable change in behavior cannot be answered in this evaluation. Nevertheless, the qualitative evidence contained in the case studies that follow generates some promising hypotheses. While lengthy institutionalization or residential treatment may have provided a venue in which youth could learn some new skills and some self-control, including the breaking of drug habits, it is difficult to see how that would translate directly and successfully into community living, effective work habits, abstinence in an open setting, and adequate social skills. It is also difficult to see how an individual builds self-confidence, self-respect, and confidence in his or her future after spending lengthy periods of time divorced from the realities and exigencies of independent community living.

Ultimately, the belief in the viability of treatment in a closed setting is based upon the assumption that the problem is "in" the person, rather than that the problem lies in the interaction and interdependence of the person and his or her several environments (i.e., school, home, work, social network, and community). Individualized, wraparound services are based upon the belief that an individual's best hope for treatment is in receiving support in the real context of his or her life, working through issues while living in and dealing with those real environments. In 9 of the 10 cases in this study, the second premise was emphatically demonstrated. Even the 10th case demonstrated that a lengthy institutionalization may bring dangerous, self-destructive behavior under control in that specific setting, but may do little to help translate this into the community setting. For this individual, the community treatment and rehabilitation effort had just begun.

A final word, however, is that all the youth in this study remain at risk, at risk for losing the fine edge in their personal and social adjustment. Most continue to live economically on the margin of society, with no great prospects of being able to achieve financial or personal success as measured by most of society. Many of their support networks are individuals who also live a marginal social and economic existence. It is unrealistic to believe that a few years of successful, respectful, stable, interpersonal and community living in the later years of their adolescence can inoculate them against the vicissitudes and personal challenges that they will undoubtedly encounter in the future. At the time of the study, they felt empowered and were knowledgeable about services, how they worked, and how to seek support and assistance if they felt they needed it. Whether that is sufficient to sustain continued, untroubled adult independence is certainly uncertain and questionable.

The two youngest in this study had the possibility of experiencing a stable, supportive, and positive socializing environment throughout a much longer segment of their developmental period than the older youth. They have the opportunity for successfully practicing more positive social and personal behavior and reaping the benefits over a much longer period of time. They also have the opportunity to develop and maintain positive and stable role models and social supports for a longer period while they build the skills which may afford them a greater chance to access the available models for successful lives as adults. Their prognosis should justifiably be better than that of their older peers. Nevertheless, as with other persons with disabilities, communities need to expect and to be prepared to provide supports from time to time in order to facilitate their efforts to live independently. As AYI has demonstrated, success can be achieved, one kid at a time, one step at a time.

4. *Mental Illness* - Youth experience a mental illness or emotional disturbance which is classified according to the DSM-III schema, although the validity of that diagnostic system is in question.

5. *Duration* - Disability has been of at least one year's duration (or conditions exist where professional judgment indicates that the disability is highly likely to be of at least a year's duration).

AYI essentially adopted these criteria. Its priority population thus became those children and adolescents who experienced severe disturbance with resulting marked functional disability; who experienced multiple needs which had to be addressed by two or more different types of services; and who experienced severe and multiple needs which were, or were likely to be, long enduring. Common professional usage (Stroul & Friedman, 1988; Torrey, Erdman, Wolfe, & Flynn 1990) identifies this group as ". . . youth with severe emotional disturbance," referred to as SED youth. Silver (1988) has proposed a set of diagnostic categories which, in sum, largely characterize the CASSP priority population. These diagnostic categories are: pervasive developmental disability (e.g., autism), mental retardation with other behavioral symptomatology, the affective disorders, schizophrenia, and conduct disorder. The vast majority of AYI youth had been previously identified with at least one of these categories.

Thus defined, AYI addressed the needs of only a small fraction of the Alaskan priority (SED) population. Although AYI accomplished the goal of virtually ending out-of-state placements and also produced a number of service system ripple effects, in scope it remained essentially a demonstration project. By the close of Year 5, a total of approximately 132 youth had been accepted into AYI's service (Sewell, 1991d).

Principal Features of Individualized Care

During the 5-year demonstration project, 10 principal features emerged which appeared to contribute to effective individualized care (Sewell, 1990a and c). Each is briefly discussed below.

Building and Maintaining Normative Lifestyles

The first dictate of the helping professions is to do no harm. Over the last 40 years, evidence has accrued in the literature that aggregate care and congregate living arrangements can do substantial harm to persons with disability and/or disturbance. It is now more clear than ever that placement of a youth in aggregate care does not necessarily equal appropriate treatment (Duchnowski & Friedman, 1990). Problems with deviant modeling, lack of access to normative social networks, availability of contraband, victimization, undue stigma, and marked difficulty in program management, among several other problems, have all been amply documented (O'Brien, 1987). Nationally, the developmental disabilities service community has long articulated the value of mainstreaming persons with disability (Wolfensberger & Glenn, 1975). For AYI, this came to mean that individualized care should employ practices which are not unduly invasive and which do not create lifestyles grossly different from those of the general culture. This feature meant that individualized care and resulting lifestyles should be as culturally, ethnically, and age appropriate as could be arranged (Cross, Bazron, Dennis, & Isaacs, 1989). AYI's own experience soon made clear that the odds of success were enhanced if youth were served away from other persons with marked disturbance or disability and were dealt with as individuals within their own communities as much as possible.

A second aspect of building and maintaining normative lifestyles was deemphasizing a "cure" orientation for services and, instead, emphasizing the development of service strategies which support the youth's repertoire. The literature offers few examples of severe emotional disturbance being "cured." Supported living, supported learning, and supported employment service strategies (Rusch, 1989) all provide for ongoing maintenance of behavioral and quality-of-life gains in the least restrictive, most normative environments which can be arranged.

Ensuring Client-Centered Services

Traditionally, predesigned blocks, or components, of service are purchased from vendors by funding agencies with the use of relatively inflexible, or categorical, funds (Thompson, 1989). Such services tend to serve only given types of clientele, are available for only specified durations, and tend to be highly stylized. Component services are likely to have extremely limited flexibility regarding the types of services delivered, the types of staffing patterns available, locations of service delivery, ongoing modifications of service plans, and case-specific commitments of additional resources. Via what might be termed the "pull-out approach", youth often are brought to and are congregated at centralized facilities far from their home communities. Component services tend to exclude, or to serve poorly, youth with multiple, severe, and long-enduring needs. The traditional case management practice of brokering (fitting) youth into existing service slots (e.g., openings, beds, homes, or programs) is often only marginally useful. Component services typically change very little in the face of a youth's highly unique and/or evolving needs. The result is that the "fit" is often poor. As such services fail, these youth are said to fall through the cracks.

With a mandate to serve out-of-state youth suffering extreme need, AYI came to recognize the value of using service plans which were multidisciplinary in origin and holistic in scope (Sewell, 1991c). Traditional psychiatric diagnostic categories tended to lend little to service planning, in part because of the highly idiosyncratic nature of a given youth's resources and challenges, even for those youth with identical diagnoses (Lourie, Behar, & Sewell, October, 1989). By degrees, individual service planning evolved. Highly personalized, youth-specific local service planning groups called Core Services Teams (CST) developed Individualized Service Plans (ISP). Critical to the effectiveness of needs-based service plans is the ability to assign substantive, client-specific resources carefully based on such plans (Friedman, 1988). As AYI increasingly moved toward client-centered services, the need to budgetarily treat each youth as an individual cost center became more pressing (VanDenBerg, 1990).

Providing Unconditional Care

Inclusionary Intake. Unconditional care meant that youth would not be rejected or found ineligible for AYI services because of the severity or multiplicity of their need (Dowrick, 1988). There developed a firm commitment within AYI to provide care to those youth with the most severe emotional disturbances. There were some youth who were accepted into AYI not necessarily because they were Alaska's most desperate and dispossessed citizens, but because of intense political pressures which were engendered on their behalf. The point here, however, is that youth were not found ineligible because their needs were too severe. For AYI, unconditional care came to mean that its individualized service had an inclusionary, rather than an exclusionary, intake policy (see Population section).

Youth Won't Be Dropped. In component services, extreme behaviors or severe needs often become grounds for a youth's dismissal from programs even though such challenging behaviors may be the very ones which defined the youth as qualified for that program in the first place. Thus, for AYI, unconditional care also came to mean that once a youth was found eligible for service, then that youth would not be dropped as a result of extreme needs which might become manifest (Burchard & Clarke, 1990). The mandate became "to do whatever it takes" to ensure that youth receive appropriate, effective services within the least restrictive environment possible. From this perspective, unconditional care allowed for occasional changes in placement, in placement type, and in community of service. Changes in placement sometimes clearly needed to occur, yet this is very different from being dropped from services as a consequence of bad behavior.

If extreme, challenging behaviors developed and produced service crises, then services were configured and reconfigured until there was resolution (VanDenBerg, 1988). The goal was to continue services for a youth until he or she had assumed a normative lifestyle and no longer needed AYI supports (AYI Interdepartmental Team, March 1991). In the early days of the program, little was known about how to actually create an unconditional care approach. As a result, a number of the early AYI youth fell through the cracks. Nonetheless, within AYI there developed an ethic that discharge from the AYI program would not be used, under any circumstance, as a threat against the youth in an effort to produce behavioral change. By degrees, it became increasingly difficult for anyone to conclude that a youth just didn't fit into existing services and thus needed to be dropped from AYI. Instead, when a lack of fit occurred, individualized services were reconfigured to match the youth's current needs. Those who provided a youth with individualized care would change the service plan, change service monitoring and information-flow channels, adjust the youth's case-specific budget, and buy or build new services relevant to the new circumstances. To sharpen the lines of accountability, one person, AYI's Local Coordinator, was assigned responsibility to ensure that services stuck with the youth, and that services and associated budgets were configured and reconfigured as the youth's needs changed. In practice, the ability to creatively develop robust and tailored therapeutic residential services was one of the most crucial elements in being able to keep the unconditional care commitment and, thus, to keep the youth in his or her community of tie.

Planning for the Long Term

Support Strategies. Because AYI focused on youth with severe, multiple, and enduring needs, it was soon apparent that AYI youth were likely to remain in the program for extended periods of time. For example, during Year 1, no youth were discharged from AYI. In Year 2, only 11 were discharged (Sewell, 1991d). In regard to service planning, AYI increasingly recognized the chronic nature of the disabilities which these youth experienced. Service delivery to AYI's SED youth came to increasingly resemble those strategies employed by the developmental disabilities services community. AYI's efforts came to focus more on support strategies (such as helping youth to live, function, behave, and adjust better rather than focusing on discussion of "cure" strategies). Kazdin (1988) has provided a useful chronic disease model as a guide to improving support services for youth with severely maladpted behaviors.

Proactivity. Success for AYI was not based on expectations that episodes of disruption would be eliminated for a given youth. Rather, it was assumed that such episodes would occasionally continue to occur and that these always had the potential of constituting crises for the youth, the family, and even the service system. Service planning based on the crisis assumption required assurance that those adults who surrounded a youth should expect crises, have preplanned interventions, and focus on gradual improvements. The objective was to help make episodes of disruption and crisis less intensive, shorter, less alarming, and less dangerous. AYI staff were encouraged not to view crises as reasons for giving up on the youth nor as causes for radical changes in placement. To deal with episodic crises, the youth's Core Services Team was encouraged to adopt a proactive approach, not to wait for crises to develop. By the end of AYI's Year 5, most of the Individualized Service Plans contained contingency plans for crises, complete with short-term, back-up alternatives such as brief hospitalization.

Generalization and Maintenance. For AYI, planning for the long term came to mean focusing on supported living (planning for 24-hour-a-day supports, if necessary) as opposed to relying on such traditional approaches as outpatient "50-minute sessions." Planning for chronicity meant focusing on "wrapping" residential and daily structure supports around the youth so as to build sustainable lifestyles with sustaining relationships. This type of planning meant focusing on ways to minimize the number of placement changes, thus keeping the youth within his or her community of tie and, by this, possibly preserving continuities in the youth's life. To the extent that continuities were deliberately maintained, generalization and maintenance of treatment gains could be maximized (Johnston, 1979; Stokes & Baer, 1977). Seldom did AYI simply deliver intensive services for brief periods and then stop. Instead, attempts were made to carefully plan gradual transitions from one service placement to another, if, indeed, such transitions were required. Unfortunately, on several occasions, detailed transition planning was not accomplished, diminishing a youth's substantial gains. Careful provision for behavioral generalization and maintenance proved critical in assuring that a level of improvement continued after a youth left a given intervention.

Working Toward Least Restrictive Alternatives

Normative Environments. It became an ethic of AYI to serve its youth in the least restrictive ways possible. In part, this meant that AYI was dedicated to delivering appropriate services to each eligible youth in as normative an environment as possible and in a manner as minimally intrusive as possible (see Mission section). In the early years of AYI, and particularly in the Southcentral region of Alaska, non-normative, highly restrictive placements were used with considerable frequency (such as in residential treatment facilities, long-term inpatient psychiatric wards, and juvenile justice centers). The habilitative results of this practice were routinely negative. In part as a result of this experience, by the end of Year 5, AYI's Interdepartmental Team (IDT) passed a policy which disallowed further use of aggregate care (in particular, residential care facilities and group homes) for all program youth (AYI Interdepartmental Team, March 1991). The foregoing should not be interpreted to mean that AYI stood opposed to short-term inpatient psychiatric stabilization services. Many AYI youth required short-term inpatient stays which were requested, and endorsed, by program staff.

Return to Community. When it was necessary to place a youth in restrictive care, there was a concerted effort to transition the youth back to more normative settings as soon as demonstrable behavior change allowed. Whenever restrictive care was used, an effort was made to approximate normative, daily living as much as possible (such as placing youth in intensive, therapeutic foster care and family-style group homes). When circumstances allowed, decisions to place youth in highly restrictive settings occurred via consensus of the youth's Core Services Team. If the CST's decision was to place the youth in restrictive care, then planning for eventual community reintegration was often begun at that initial meeting when placement was decided. Once placed, the goal was always to rapidly transition the youth back to normative services delivered within the mainstream culture. The time, resources, and advocacy necessary to arrange for these youth-specific deinstitutionalizations were often extreme. As a consequence, by the end of Year 5, AYI's policy was to leave affected youth on the "sending" coordinator's caseload (with associated resources provided) rather than drop the coordinator's assignment while the youth remained in the facility.

Dimensions of Restriction. Restrictiveness can be thought of along several dimensions: physical, programmatic, chemical, geographic, and social (Sewell, 1991b). Each of the these five dimensions must be monitored constantly by the coordinator as well as by the whole CST. However, a particularly vexing and common type of restriction experienced by Alaskan SED youth has been geographic, wherein youth are removed from their community of tie and then sent to out-of-region facilities. This practice has often had several untoward effects, among the more serious being that a youth's links and relationships to his or her community of tie were disrupted or even destroyed. Undue placement in out-of-region facilities has often been predicated on the assumption that intensiveness of service equates with type of facility. That is, a youth could only receive "real" habilitation when placed in a hospital or treatment facility. In turn, this meant that the youth must, of necessity, be removed from his or her community and/or region. The placement histories of most AYI youth were littered with these types of service failures. Of course, the common rationale provided by service vendors was that distant, highly restrictive placement was in the youth's best interest, meaning that if the youth remained in his or her community, then he or she would constitute a danger to self and others. However, careful examination of the evidence usually revealed that the issue boiled down to staffing, supervision, and staff-skill problems.

Empirical Question. Regardless of the dimension of restrictiveness, what constituted the least restrictive alternative for a given AYI youth was always an empirical question. That is, the answer was always related to what services could be created for the youth and how effective those services would be. The thinking regarding SED services was, and still is, that workers have little ability to predict what can, in fact, constitute the least restrictive alternative for a given youth. As a matter of course, Local Coordinators were faced with the question, "What do we need to find out?" The answer always related to what resources, creativity, risk management strategies, and staff skills could be intensively applied to the youth's service.

Achieving Provider Competencies

New Roles. With a mission to build and maintain normative lifestyles for SED youth, AYI faced the problem of providing staff-intensive supports in completely community-based settings. AYI workers needed to be very actively involved in the actual living and learning environments of each youth. Workers needed to directly teach the age- and culture-appropriate social, daily living, and job skills necessary for youth to successfully adjust in their communities. Closely associated with this was the routine need for workers to identify many naturally occurring resources within particular lifestyles of the youth. All this meant that staffing patterns, staff support strategies, and consultative and supervisory approaches needed to follow AYI youth out into their respective communities. This often required markedly new roles for AYI personnel. Considerable flexibility was also required in the development of highly personalized job descriptions, schedules, and the like. For example, varied contractual arrangements (as opposed to employeeships) were made, often with non-profit, private human service vendors as a way of coming up with the highly specific youth-worker "matches" in terms of mentors, aides, foster parents, companions, and supervisors. The unique qualities of some AYI youth, coupled with the rural and often remote nature of Alaskan lifestyles, encouraged the use of workers with varied types and levels of professional and experiential preparation.

Sources of Competence. Demonstration projects for services to severely needy clientele often have strong human resource development components (Christian & Hannah, 1983). However, during its initial 5 years, AYI never substantially achieved this. As a result, staff quality varied wildly across coordinatorships. There were several reasons for this deficit. A largely unavoidable one was that Alaska had, and still has, a marked absence of both service provision and training infrastructures. Nonetheless, considerable case-specific staff training was used with benefit (Oakley, 1988). In addition, some broader scale attempts at foster care training were tried. On balance, though, these efforts highlighted the truism that for training to have enduring impact, it needs to occur in a supportive context (Stolz, 1981). That is, efforts to provide training, per se, in the relative absence of the other aspects of individualized care (such as flexible funding and accountability) produced little continued success.

For these and other reasons, staff recruitment and selection was relied on heavily to provide the workforce necessary to serve the AYI cohort. Because of the extreme expense these youth could potentially represent, sufficient resources were commonly made available to attract and retain quality personnel. Workers with developmental disabilities service backgrounds proved to be particularly adept at grasping the mission and executing the responsibilities of AYI.

Obtaining Consensus Among Key Decision Makers

Interagency Collaboration. Early on, it became apparent that effective, holistic services for multiple-need youth required a high degree of interagency collaboration (Bruner, 1991). In particular, this collaboration needed to occur at both Interdepartmental Team (system) and Core Services Team (case-specific) levels. Successful Local Coordinators developed the skill of identifying, convening, and maintaining workable youth-specific groups of those key decision makers in each assigned youth's life. The performances of Core Services Teams were facilitated by the Local Coordinators. The major positive outcome was the production and maintenance of consensus between the youth's key decision makers regarding what characterized the youth's recent history (i.e., the preceding 90 days), what his/her specific needs were, what was in his/her best interest, and what the service plan would be for the ensuing 90 days. This consensus was critical because the multiple vendors typically involved in a youth's life often had sharply divergent views concerning these four issues. On a case-specific basis, this interagency, consensual process had to evolve but often required guidance and heart-felt advocacy by Core Services Team members.

Funding Services With Flexible Budgets

Money Follows the Client. As a matter of business, each youth in out-of-state placement had specific, large amounts of money encumbered in his or her name for the purpose of meeting the holding facility's costs. Recognizing that intensive, community-based Alaskan alternatives would, at least initially, incur comparable expense, an effort was made to ensure that, whatever monies had been budgeted for the youth's out-of-state services, a similar amount of funds would be made available for services within his or her community of tie. It was in this sense that money was said to "follow the client." Once the youth was served within his or her community of tie and marked service change(s) became necessary, then the encumbered monies were allowed to be spent on newly identified service needs. This was the rudimentary beginning of having clients represented as individual cost centers at both the funder and vendor levels.

Identification and Brokering of Existing Services. Usually some relevant parts of the service continuum did exist within a catchment area (Jones, McDanal, & Parlour, 1985). An effort was made to use these component services as much as possible and meant that expenses assigned to AYI's flex-funds were minimized. Relevant line or supervisory workers within employed vendorships often became members of the youth's group of key decision makers (see CST section, below). In any case, even judicious use of the component care system often left large pieces of the youth's service plan without appropriate resources. By degrees, individualized budgets became more systematically available to fund those parts of each youth's plan which were not resourced through the component system.

Move Toward Individual Cost Centers. Numerous problems and points of contention developed during the effort to move away from categorical funding of service components and toward flexible funding of individualized care. Not only was this more rife with technical and regulatory problems, it also represented a marked shift in the potential benefits and risks for varied, key stakeholders. As might be anticipated, those who had the greatest vested interests (real or perceived) in categorical funding of component care became some of those who were most opposed to flexible funding of individualized care.

Parts of Each Individualized Budget. Over a 5-year period, there evolved a means to provide each accepted and assigned youth with an Individualized Budget (IB) (VanDenBerg & Sewell, 1991). Each Individualized Budget consisted of three parts: C1, C2, and C3. The part labeled C1 represented the youth's Local Coordinatorship cost which included such items as the coordinator's salary and other directly associated expenses (such as the coordinator's phone); C2 represented all other operating expenses (for the vendor) which were not youth specific and included such items as a small portion of the vendor's rent, insurance expenses, and accounting costs; and, C3 represented all those costs which were strictly identifiable from the youth's Individualized Service Plan. Expenses in C3 were derived from the ISP in a manner that provided a point-to-point correspondence between those action steps found on the ISP and those budgeted costs found on the IB. Together, C1 and C2 were termed the youth's Core Service Costs, while C3 was termed the youth's Flexible Service Costs.

Core Service Costs (C1 + C2). While a given youth's Flexible Service Costs (C3) could vary over a wide range depending upon an ISP's content, each youth's Core Service Costs (C1 + C2) were fixed and were ascertained by formula. For the statewide program, the value of C1 was determined by estimating the entire direct cost of one full-time case coordinator, and by assuming that a full coordinatorship case load would be six youth. In addition, C2 was determined by formula as being a proportion of C1 costs. The economic reality of the C2 value was ascertained by a group of exemplary providers who established it as 1/3 the cost of C1. Thus, C1 = (Coordinatorship and Associated costs/6); C2 = C1/3); and Core Service Costs = (C1 + C2).

By the close of AYI's fifth year (1991), as a result of the program's experience and based on the Alaskan economy, C1 was set at $9,000 and C2 was set at $3,000 per annum; the Core Service expense was $12,000 per youth per annum. Core Service Costs were prorated; if a youth entered the program 6 months into the fiscal year, the vendorship received 0.5 of the Core Service Cost's per annum value.

Flexible Service Costs (C3). A youth's Flexible Service Costs were derived from a direct costing out of the action steps listed on the youth's ISP. The layout of the C3 budget exactly mirrored that of the ISP. The purpose of this was to have a direct relation between fiscal and programmatic accountabilities. The coordinator had primary responsibility for ensuring that all C3 costs were related to the action steps listed in the youth's ISP in a direct, point-by-point manner.

As mentioned before, many ISP action steps could be resourced through existing categorical funding streams. For example, respite care might be provided through an existing, paid for respite service using a voucher system. In a second example, varied services might be included on a youth's Individualized Educational Plan (IEP) and paid for through the school district's special education department. Additionally, wherever possible, Medicaid, private insurance, and CHAMPUS (insurance for military dependents) were pursued as payers of first resort. However, once all traditional brokering and case management steps were complete, there typically still remained several service needs which could be covered in no other way than through the use of highly discretionary, flexible funds. For this, there existed no programmatic cap regarding either the identity or the amount of an allowable expense, within broad limits. Fiscal oversight principally sought to establish that ISP action steps were reasonably developed (in content and format) and that resulting costs were derived in a direct and frugal manner. Laced throughout the flexible budgeting process was the recognition that early on services would often be intensive (and thus expensive) in a youth's intervention, and that those services, and associated expenses, for this youth were most likely to be known by adults closest to the youth and not by state-level bureaucrats.

Budget Request. A submission-of-budget request involved sending the detailed Individualized Budget, along with the associated ISP, to the State IDT for signature. Upon approval, the coordinator's agency would then submit a grant amendment to the State Division of Mental Health and Developmental Disabilities, as well as similar forms of request to the Division of Family and Youth Services and the Department of Education, depending upon the idiosyncrasies of a given youth.

Providing a Gatekeeper Function

Many Alaskan SED youth experienced removal from their community of tie because, in fact, an individual caseworker was exhausted, irritated, frustrated, unimaginative, concerned about his or her perceived personal liability, and/or lacked immediately available resources. Virtually all AYI youth had long and littered histories of summary removal from their homes, communities, regions, and even from the state, often due to a range of system issues. These reasons for invasive placement are quite different from those provided by an independent, interagency review committee which has carefully examined a range of evidence and has concluded that a youth is fundamentally unservable within his or her own community.

Early in the evolution of AYI, there emerged an apparent need for a clear separation between the mechanism which decided individual youth eligibilities (the jury) and the mechanism which arranged for and provided direct services to accepted youth. Without a clear separation, it was too easy for the service system to conclude that a given, highly troubled youth no longer warranted community services. The explanations to account for these exclusionary decisions were often ornate, and, of course, typically referenced the youth's best interests, but careful review of the details often revealed additional issues such as the convenience of staff, difficulties in reaching the family, and expense to the provider agency.

It was in this context that AYI eventually evolved the Interdepartmental Team structure which had a limited set of functions, one being to identify eligible youth. The state-level IDT, not local service agencies (alone or together), decided which youth constituted the priority population. This decision involved both the acceptance of youth into the program and the discharge of youth from the program. It was in this sense that the IDT was said to serve a gatekeeper function. This case review process provided a relatively independent authority which could make substantive decisions regarding a youth's service alternatives and welfare, apart from the immediate pressures and limitations of local service capacity. This process has been generally recommended by the National Mental Health Association (National Mental Health Association, 1989) and has also found some use in the developmental disabilities service community.

This process helped to determine as eligible only those youth who were the most difficult to serve, to focus on them for as long as they continued to evidence severe need, and to maintain this focus for only as long as priority services were needed. AYI's IDT gatekeeper function thus became one of the critical elements which helped to create unconditional care (see also, Unconditional Care section).

Appendix C
Iowa City Collaborative Integration Project

Appendix C
Iowa City
Collaborative
Integration Project

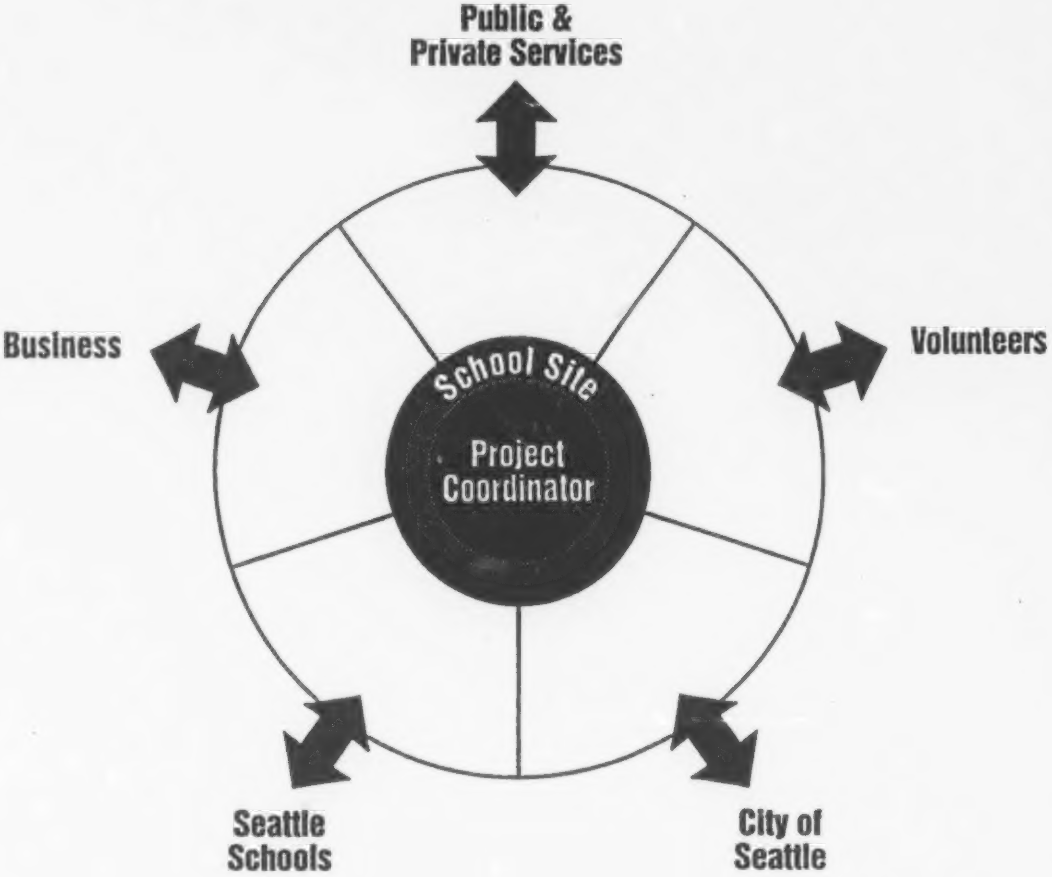
Cities in Schools information provided by the Cities in Schools project.

MATERIAL NOT COPYRIGHTED

The CIS Strategy

The Coordination of Resources at School Sites

Administered by a Project Coordinator utilizing an accountable and personalized delivery of services to children, youth and their families, with an emphasis for serving those children and youth who are at-risk.



Public & Private Services

Business

Volunteers

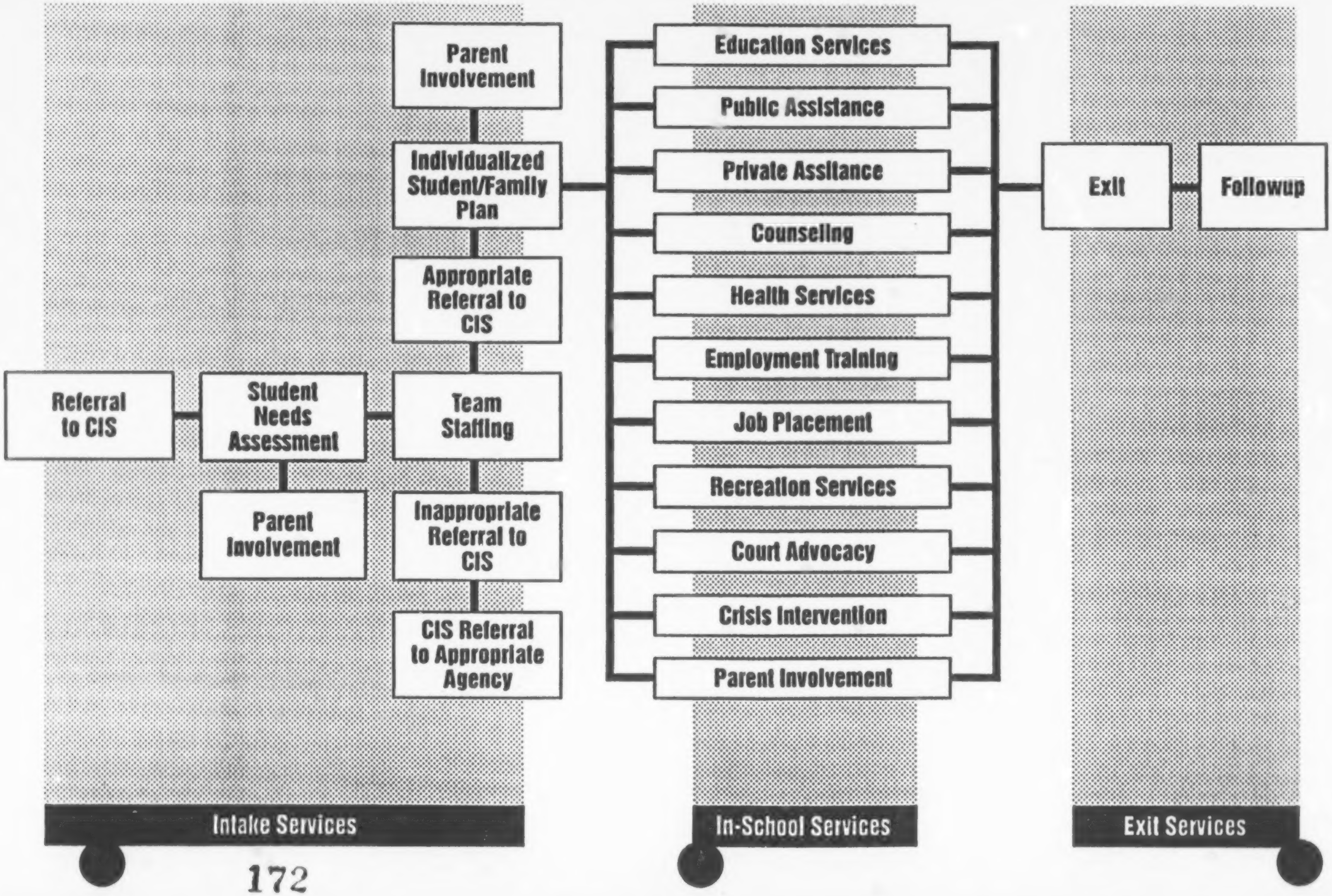
School Site

Project Coordinator

Seattle Schools

City of Seattle

Cities In Schools Reponse to At-Risk Youth and Their Families



Referral to CIS

Student Needs Assessment

Parent Involvement

Team Staffing

Appropriate Referral to CIS

Individualized Student/Family Plan

Parent Involvement

Inappropriate Referral to CIS

CIS Referral to Appropriate Agency

Education Services

Public Assistance

Private Assitance

Counseling

Health Services

Employment Training

Job Placement

Recreation Services

Court Advocacy

Crisis Intervention

Parent Involvement

Exit

Followup

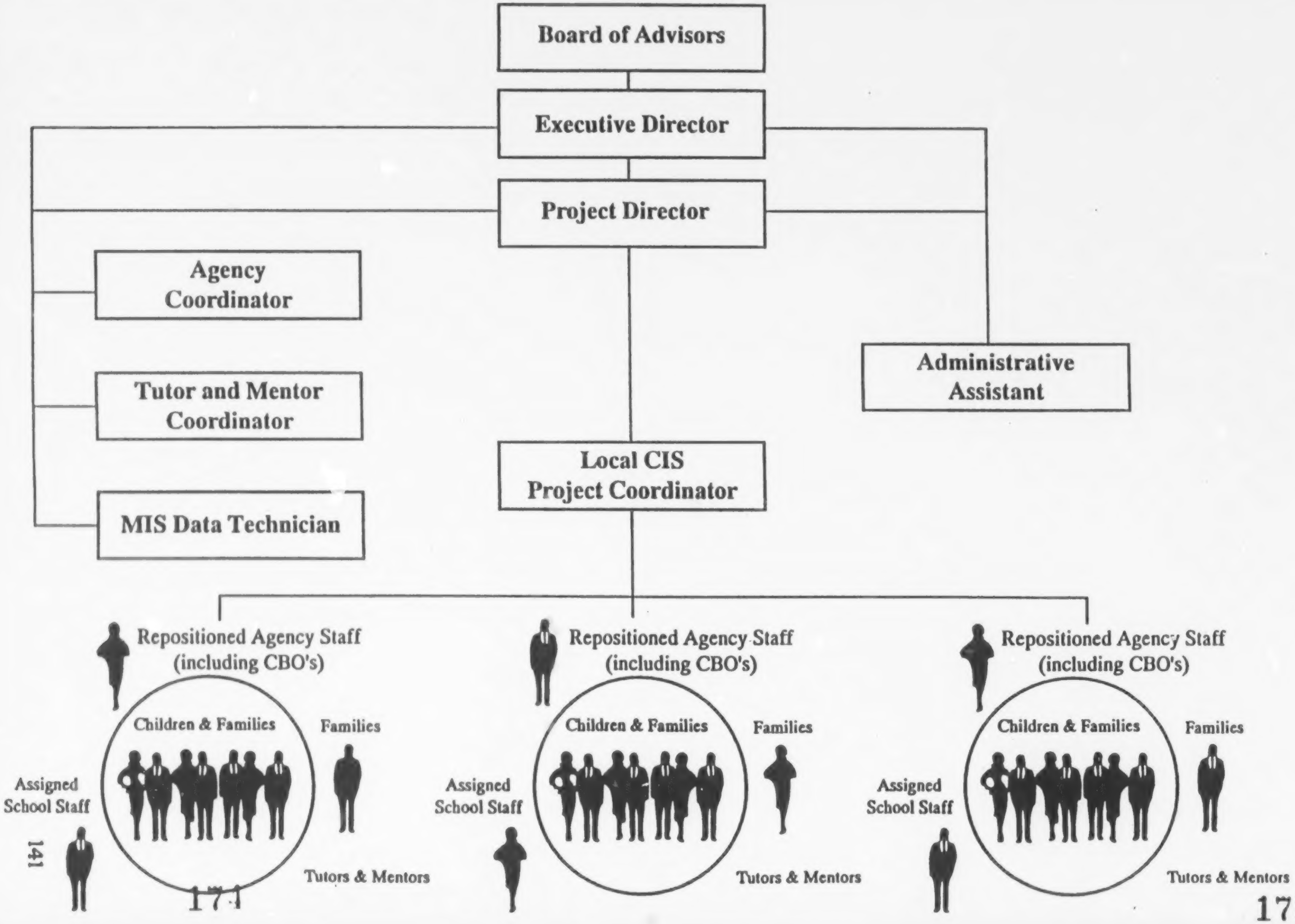
Intake Services

In-School Services

Exit Services

CORPORATE GRAPHICS 8/24/91 OSM002-3

The Management Team



Board of Advisors

Executive Director

Project Director

Agency Coordinator

Tutor and Mentor Coordinator

MIS Data Technician

Administrative Assistant

Local CIS Project Coordinator

Repositioned Agency Staff (including CBO's)

Children & Families

Families

Assigned School Staff

Tutors & Mentors

Repositioned Agency Staff (including CBO's)

Children & Families

Families

Assigned School Staff

Tutors & Mentors

Repositioned Agency Staff (including CBO's)

Children & Families

Families

Assigned School Staff

Tutors & Mentors

Appendix D
Kaleidoscope

Browning, A., Ellsworth, P., Lawrence, L., McCarville, S., Wicks, C., & Wildman, G. (1993). *Behavior disability curriculum for the ICCSD K - 12*. Iowa City: Iowa City Collaborative Integration Project.

MATERIAL NOT COPYRIGHTED

BEHAVIOR DISABILITY CURRICULUM

FOR THE ICCSD K-12

Ann Browning, Elementary Disability Teacher
Paula Ellsworth, High School BD Teacher
Linda Lawrence, Junior High BD Teacher
Sheila McCarville, Elementary BD Teacher
Connie Wicks, High School BD Teacher
Ginny Wildman, GWAEA Special Education Consultant

SUMMER 1993

This project was funded through a grant
from the U.S. Department of Education.
(award#H237B20009)

BELIEFS OF THE ICCSD BEHAVIOR DISABILITY PROGRAM

- The school has a central role in developing the emotional, behavioral, and social health of students as it is the one institution that touches the lives of *all* children.
- Services for children and youth with significant behavioral difficulties must be provided within the context of a larger building-wide commitment to the social, emotional, and behavioral development of *all* children.
- The education of the total child includes a balanced focus on both academic and social needs.
- Social, emotional and behavioral support structures benefit *all* students.
- Behaviors are best taught in a planful, proactive, and consistent manner.
- Inappropriate behaviors warrant instruction and/or natural or logical consequences or teaching rather than punishment.
- The creation of a positive learning environment conducive to the social and emotional health of *all* students begins with the care and concern of a professional staff.
- The teacher becomes the student's case manager and coordinates the services within the school setting to meet the student's social, emotional, and behavioral needs.
- Cultural differences are valued and always considered when developing student expectations and responses to behavior.
- The child is a part of a family with complex needs and strengths. Parents, families and schools are partners in planning for the student.
- By meeting the needs of students with significant behavioral difficulties, the capability of schools to deal with *all* students is increased.

Adapted from the Colorado State Behavior Disability Curriculum

PROGRAM OUTCOMES

1. Positive school climate.
2. Increased staff acceptance of *all* students.
3. Increased student and parent satisfaction with school.
4. Improved cooperation and effective interagency collaboration.
5. Increased early identification and intervention.
6. Increased appropriate use of community resources.
7. Increased participation by school personnel.
8. Changes in rules and policies to reflect support for best practices.
9. Decreased retention rates.
10. Reduced use of suspension and other exclusionary measures.
11. Appropriate referrals, as needed, to outside sources for behavioral needs.
12. Decreased out of school or home placements.
13. Decreased incidence of suicide, drug use, sexual abuse, physical aggression.
14. Decreased drop-out rates.

Adapted from the Colorado State Behavior Disability Curriculum

STUDENT OUTCOMES

EDUCATIONAL EXPECTATIONS

- Achieves in school commensurate with ability.
- Completion of local school minimum graduation requirements.
- Participates fully in school and related activities.

SOCIAL/BEHAVIORAL SKILLS

- Increased internal control of behaviors resulting in appropriate social behavior.
- Conveys thoughts and feelings in socially acceptable ways.
- Establishes positive and lasting peer interactions.
- Participates in productive group activities.
- Develops a range of personal skills to occupy free time.
- Demonstrates respect for human diversity - cultural, racial, ethnic, gender, disability.

INDEPENDENCE/RESPONSIBILITY

- Regularly attends school.
- Sets goals and perseveres toward their completion.
- Implements routines, applies strategies, accesses resources to follow tasks through to completion.
- Advocates for self when appropriate.
- Engages in career planning and/or employs job procurement strategies.
- Assumes responsibility for self.

PHYSICAL/MENTAL HEALTH

- Demonstrates respect for personal grooming and basic health care.
- Possesses a positive self image.
- Selects healthy life styles (e.g. exercise, diet, avoidance of drugs, alcohol, etc.)
- Self evaluates emotions and personal conduct.
- Demonstrates knowledge of potentially harmful behaviors and strategies for prevention or responding (e.g. aggression control, sexual activities, etc.)

CONTRIBUTION/CITIZENSHIP

- Participates in school and community projects/activities.
- Complies with school and community rules.

EVALUATION OF PROGRAM AND STUDENT OUTCOMES

The K-12 Behavior Disability teachers and associates will meet at least four times each school year in an effort to build effective communication and support among the staff. The group will share suggestions and recommendations for evaluating and enhancing the K-12 Behavior Disability curriculum.

Throughout the year various evaluation tools will be used to monitor progress in meeting the student and program objectives. Evaluation instruments will be used at least twice each year by parents, staff, and students. These evaluation instruments may be found in the appendix.

PARENTAL INVOLVEMENT

- IEP planning meeting
- Initial meeting with parents prior to school starting
- Following initial staffing into a program, the teacher, significant school personnel and parent (s) will meet to discuss the program and expectations
- Parent-teacher conferences
- Parent support groups
- Daily contact sheet between school and home
- Weekly calls/letters
- Conference calls
- Home/school contracts
- Home/school visits
- Newsletter
- Parent assisting in managing behavior at school
- Mid-terms, term grades, end of year reports
- Responsibility to have medications available at school and taken when prescribed at home
- Follow-up calls to share information regarding doctor appointments and other critical information
- Be aware of services available in the community
- Responsibility for after-school activity transportation

BEHAVIOR DISABILITY: DEFINITION AND CHARACTERISTICS

Behaviorally disabled is the inclusive term for patterns of situationally inappropriate behavior which deviate substantially from behavior appropriate to one's age and significantly interfere with the learning process, interpersonal relationships, or personal adjustment of the pupil to such an extent as to constitute a behavioral disability.

1. Clusters of behavior characteristics of pupils who are behaviorally disabled include:

Cluster I	Significantly deviant disruptive, aggressive or impulsive behaviors;
Cluster II	Significantly deviant withdrawn or anxious behaviors;
Cluster III	Significantly deviant thought processes manifested with unusual communication or behavioral patterns or both;
Cluster IV	Significantly deviant behavior patterns characterized by deficits in cognition, communication, sensory processing of social participation or a combination thereof that may be referred to as autistic behavior.

   A pupil's behavior pattern may fall into more than one of the above clusters.

2. The determination of significantly deviant behavior is the conclusion that the pupil's characteristic behavior is sufficiently distinct from that of the pupil's peer group to qualify the pupil as requiring special education programs or services on the basis of a behavioral disability. The behavior of concern shall be observed in the school setting for school-aged pupils and in the home or center-based setting for preschool-aged pupils. It must be determined that the behavioral disability is not maintained by primary intellectual, sensory, cultural or health factors.

3. In addition to those data required within the comprehensive educational evaluation for each pupil requiring special education, data shall be gathered when identifying a pupil as behaviorally disabled which describe the qualitative nature, frequency, intensity, and duration of the behavior of concern. If it is determined that any of the areas of data collection are not relevant in assessing the behaviors of concern, documentation must be provided explaining the rationale for such a decision. Such documentation will be reviewed and maintained by the director of special education.

BEHAVIOR MANAGEMENT SYSTEM COMPONENTS AND STRATEGIES

As with all curriculum decisions, the teacher should design instruction to meet the individual needs of the students. For most students with behavior problems, both academic and social behavior changes will be needed. Two important components of any program that will effectively address both academic and social behavioral concerns are effective teaching strategies and an effective behavior management system.

Effective teaching strategies have proved to optimize the academic performance of students with disabilities. Enabling a student to be academically successful often leads to fewer behavioral problems in the classroom. Likewise, an effective behavior management system will lead to fewer behavior problems, thereby enabling the student to perform better academically. In other words, curricular choices should be made based on the student's needs, and they will be most beneficial and motivational if used in conjunction with effective teaching strategies and effective behavior management systems.

An effective behavior management system must have a competent professional and support staff working in an innovative and supportive environment. In order for behavior disability programs to work, professionals must have available to them a variety of methods to meet the varied and individual needs of each student. These methods then must be put into a sensible and practical organizational system that can be applied in individual school situations.

While professionals must make available to themselves and their students a variety of approaches, these must be put into an organizational structure so that they can be applied at appropriate times and for appropriate student needs. This is a critical issue in designing behavior disability programs. It is also imperative that those strategies be backed by strong rationale and be delivered with structure, sensibility, sequence, organization, and consistency to ensure effective and efficient instruction.

A working structure - a framework in which methods and techniques can be incorporated, must come first. The framework should provide, externally, the direction or control the student lacks internally, while systematically increasing the student's capacity for internal direction. Positive alternatives to problem behaviors begin immediately to help the students develop internal controls. The goal is for the student to be his/her own behavioral manager.

A teacher of behaviorally disabled students ensures the classroom environment has an ongoing balance of three domains. These are behavior, instruction, and communication. In the area of behavior control, to be effective, the teacher must have a contingency management program that contains both a motivation system and a discipline system. With regard to the domains of communication and instruction, troubled youth have many issues of concern and most of the issues are just below the surface of the presenting problems. A great many of the here-and-now conflicts are partial re-enactments of these issues. The training of teachers of behaviorally disabled students enables them to help their students deal with these issues.

The ultimate goal for students in the behavior disability classroom is to move toward less restrictive programming, whether it be a different program model, increased participation in appropriate integrated regular education classes, or the integration of students from the regular education classroom into the special class. The multidisciplinary team (special education teacher, regular education teacher, administrator, parent(s), AEA support personnel, and other profession-

continued on next page

als) makes decisions regarding the student's placement and helps to plan the integration program that will best suit each individual student's needs.

An effective behavior management system would include a behavior intervention component with a trained interventionist and conferencing area available at all times for: 1) de-escalation, 2) problem solving and planning, and 3) returning to the regular or special education environment.

For the special educator serving behavior disabled students, several basic assumptions about programs and students must be made.

BEHAVIOR MANAGEMENT ASSUMPTIONS

Students need organized, consistent structure and predictable educational environments with the flexibility for the incorporation of teaching in spontaneous situations - teachable moments.

Complete and comprehensive information and data must be collected periodically so that the effects of interventions and instructional decisions can be evaluated and modified.

The focus of the program should be on self-management and self-monitoring skills so that the student can eventually learn to manage and adjust his/her own behavior.

Students need clearly stated program and individual behavioral goals.

Students need high expectations, but acceptance and forgiveness when expectations may not be met.

Students need exposure to humor, an optimistic attitude, and the freedom to make mistakes.

Students need consistent and clearly stated rules, limits, and consequences.

Teachers need to understand the nature of individual student problems and concerns.

Successes are the key to motivation. An effective classroom structures many opportunities for success.

INSTRUCTIONAL ASSUMPTIONS

Students need systematic instruction, whether remedial or developmental for both academic and social behavior changes.

Academic achievement and success are important components of a behavior disorder program.

Students need clearly stated program and individual academic goals.

Students need high interest, multisensory, stimulation controlled environments conducive to learning.

Curricular choices should be made based on student needs and interests and they will be most beneficial and motivational if used in conjunction with effective teaching strategies and effective behavior management systems.

COMMUNICATION ASSUMPTIONS

Communication and coordination with families is integral to student success and growth.

Close working relationships with teachers, administrators, and support staff members are crucial to a successful program.

Communication and coordination with the community agencies involved with the student and family is crucial to successfully monitor the student's progress while in school and when transitioning into adulthood.

Adapted from The Iowa Program Standards for Interventions in Behavioral Disorders, Iowa Department of Education, Bureau of Special Education, Grimes State Office Building, Des Moines, Iowa 50319-0146

Appendix E
Linn County Youth Service Teams

Kaleidoscope, Inc. information provided by the project.

MATERIAL NOT COPYRIGHTED

Kaleidoscope, Inc.

1279 North Milwaukee Avenue, Suite 250 Chicago, IL 60622

(312) 278 - 7200

Kaleidoscope, Inc. is a licensed, not-for-profit child welfare agency that specifically serves children and youth considered to be the state's most-in-need. The agency is supported largely by general grants and individual contracts with the Illinois Department of Children and Family Services, the Department of Mental Health and the Department of Corrections. Corporate and foundation grants and individual contributions support additional services and activities not covered under government contract.

Service Philosophy

Kaleidoscope, Inc.'s mission calls us to reach out to children who are most in need; our philosophy calls forth principles that enable us to serve troubled youth humanely and effectively. This philosophy is based on two concepts: normalization and unconditional care. The basic premise of normalization is that children can best learn to become normal, competent adults if they live in and learn from a normal environment -- a family, a neighborhood, community. Unconditional care extends the right of parental care to children who are state wards or who do not have parents to care for them. It asserts that children need loving care regardless of their behavior, and rejecting them from care for misbehavior worsens their condition and our society's burden.

These two concepts generate the key principles that form the basis of Kaleidoscope's programs and services which are:

- To accept into care those children who have been in or are bound for institutions, which are the least normal environment and injurious to children,

- To serve children regardless of the severity of their behavioral problems, emotional disorders or handicaps,

- To provide family services to prevent child placements or to reunite children in placement with their families. When children must be removed from their own families, we provide them with substitute care in families. Our agency becomes an "extended family" to the children we serve,

- To believe that care givers – parents, child care workers, foster parents – are the most important treatment resource for children, for they provide role models and loving parental care. Clinical professionals are available to care givers to provide specialized treatment and consultation, but the 24 hour care givers are "in charge" of the children's services,

- To help children, youth and their families be self-sufficient, and to live as normally as they possibly can. For younger children, giving them the security of a stable family life and ensuring that they get a good education are central to their growth and development. For older youth, major service goals include helping them acquire job skills, independent living skills, and ensuring that there are people in their lives who are "family,"

- To advocate for better policies and programs for children who are considered most-in-need.

Programs

Kaleidoscope, Inc. provides three basic program models. However, true to our service philosophy, each child has an individualized service plan so that the program is tailored to meet the specific needs of the child. Further, the services designated in the service plan are provided with flexible intensity. We seek to give each child as much service support as is needed at any one time. Collectively, our programs provide an array of care so that children can move from one program to another as their needs and circumstances require.

The **Therapeutic Foster Family Homes Program** serves over 70 children and youth daily. Professional foster parents are paid and trained to provide full-time care in their own homes, to handicapped and troubled youth. These foster parents find appropriate schools for the children, secure therapy and medical treatment for them and, most importantly, provide loving parental care. Some children live with professional foster parents and their families until they reach adulthood. Some return home after a time. Some move from therapeutic foster homes into independent living programs. Within the Therapeutic Professional Foster Family Home Programs are two very specialized services. The *Adolescent Parents Program* provides professional foster care for state wards who are pregnant or parents, as well as for their babies. The *STAR Program* secures professional foster parents and state of the art health care for babies with HIV, ARC, or Acquired Immune Deficiency Syndrome.

The **Youth Development Program** places and supervises over 44 older youth in apartments in the community in order to help those who have grown up in the foster care system learn to live on their own. Approximately fifty percent of the clients are adolescent parents. Helping these youth become self-sufficient is an enormous task. Many of the youth are functionally illiterate and sorely lacking in work habits and skills. Our youth workers focus on job-seeking and retention skills, developing jobs, enrolling youth in basic education classes, teaching basic independent living skills such as maintaining an apartment and budgeting, and helping youth overcome behavioral problems. Although the trend in the field is toward short-term independent living programs, many of our youth have severe skill deficits that require long-term intervention. A minimum one-year commitment to the Youth Development Program is required of each referring agency.

The **Satellite Family Outreach Program** provides services to over 43 families in Chicago and surrounding suburbs. Its goal is to successfully reunite children in residential treatment with their families and to prevent the unnecessary removal of children from their homes. Satellite is one of the oldest and largest family-based programs in the country. It is widely recognized as a model for working with seriously emotionally unique families.

Special Services

Kaleidoscope, Inc. makes available a number of special services to clients. They include:

- Food distribution in conjunction with the Greater Chicago Food Depository,
- The Second Chance Program of used clothing and household goods donated by staff and friends of the agency,
- Vocational counseling and testing, and
- Recreational services of both individual and team sports and special events.

Staff

Kaleidoscope, Inc. is committed to providing necessary staff support services including but not limited to: child care, assessment and diagnosis, health, clinical, adjunct therapies and consultation. We employ over 80 staff members and 60 professional foster parents. All professional staff must have a Bachelors Degree, and over twenty-five percent hold Masters Degrees.

Referrals

To refer a child, youth, or family to Kaleidoscope, Inc.
write or call the Associate Director.

To inquire about becoming a Kaleidoscope, Inc. Foster Parent,
write or call the Foster Care Program Services Coordinator

To employ Kaleidoscope, Inc. youth and parents,
write or call the Coordinator of Vocational Services.

To donate cash, goods, or time to Kaleidoscope, Inc.
write or call the Development Director.

All of these people can be reached at the following location:

Kaleidoscope, Inc.
1279 North Milwaukee Avenue Chicago, Illinois 60622
(312) 278 - 7200

December, 1992

Satellite Family Outreach Program

Service Philosophy

The Satellite Family Outreach Program is a continuum of services provided by Kaleidoscope, Inc., a child welfare agency, licensed by the State of Illinois, that specifically serves children and youth considered most-in-need and otherwise destined for institutional placement. Satellite embraces Kaleidoscope's mission and philosophy of serving children and youth, summarized as follows:

- To serve children and families regardless of the severity of their behavioral problems, emotional disorders, or handicaps,
- To ensure that children and youth are not denied the experience of family and community life,
- To help children, whenever possible, by helping their families,
- To help older youth learn to become self-sufficient, whether they live with families or not,
- To advocate for better policies and programs for children and families who are considered to be most-in-need.

Kaleidoscope was founded in 1973. Today it has a budget of $4.2 million and serves 110 children per day in our therapeutic foster families program, and one supervised independent living program. In addition, the agency serves 48 families per day through its Satellite program.

Kaleidoscope, Inc.'s Satellite Family Outreach Program provides intensive services to families so that their children in residential placement can be returned home safely and to ensure that any children not in placement can remain in their own homes. The program serves seriously emotionally unique families referred by the Department of Children and Family Services (DCFS) and the Department of Corrections. Satellite families receive 80 - 125 hours of service support per month, with the majority of the service hours being provided in the clients' home. Services include help with the basics -- food, housing, recreation, child and home management -- as well as counseling and therapy. Satellite is the product of two unmet needs. The first is the need to serve more children by serving their families. Although the child welfare field has long recognized the primacy of the nuclear family in insuring the well-being of children, few child welfare services are truly family-centered. The second need is that of finding alternatives to traditional family services and family therapy for seriously emotionally unique families.

Family Characteristics

The majority of Satellite families are low-income, urban, and minority. About two-thirds are headed by women, and most of them depend on the AFDC program for family income. Heads of Satellite families, whether two parent or single parent, are typically unskilled and lacking high school diplomas. Unemployment is a severe problem, and about two-thirds of Satellite family heads are seeking work but are unsuccessful.

All Satellite families can be characterized as multi-problem and emotionally unique. In addition to having serious difficulties providing basic food and shelter for their children, these families have severe relational disturbances. Violence, abuse, sexual abuse, drug and alcohol addiction, and depression are symptoms of these families; so also are role and boundary problems – parents become children, children become parents. The consequence is that one or more of the children have presented problems severe enough to warrant residential placement, or the parents have been abusive or neglectful, warranting child placement.

Program Management

Satellite currently serves 48 families referred by the Department of Children and Family Services and the Department of Corrections. Referrals are primarily made to reunify children in placement with their families. In some cases, however, referrals are made for 90 day assessments, to help determine if placement can be prevented, or if reunification can be achieved. Each family is served primarily by a team of five Kaleidoscope staff – four Bachelors Degreed Family Workers and one Masters Degreed Social Worker. Each of these teams serves up to 12 families.

Family Workers provide a wide range of direct and collateral services, and Social Workers provide coordination of clinical services. Additional staff service support and consultation are provided by an Activities Coordinator, Vocational Counselor, Social Worker Supervisor, Family Worker Supervisors, Program Administrator, and agency management staff. Satellite is supported by purchase of service agreements with the referring agencies.

Service Delivery

Service Goals. Families are referred to Satellite for three reasons: *prevention of placement, assessment, or reunification*. When a family is referred for prevention of placement, Satellite's goal is to provide enough immediate improvement in family functioning to enable it to reach a minimal level of stability. Later, treatment focuses on eliminating the need for the child to function as the identified problem, and improving the communication and overall functioning of all extended family members. By offering services to the entire family, Satellite can often prevent the future placement of other children experiencing difficulties but not yet necessarily a part of the DCFS system. Preventive services also apply when the goal is to stabilize the child in a long-term foster home or the home of a relative.

Another service option within Satellite is a *time limited assessment of family functioning and potential.* These assessments complement the traditional individual psychological and psychiatric evaluations to provide a better understanding of a child's role within the family and the family's ability to respond to a child's needs. Teams see family members in their natural environments, where they are at ease. They assess the family relationships with each other and with support systems, in addition to their social skills and their ability to manage basic needs and parenting demands. At the end of the assessment period, a summary is presented to the referring agency. These assessments are useful in exploring permanency goals for Administrative Case Reviews, adoption possibilities, or to complete the diagnostic assessment for a child already in placement.

When reunification is the goal of Satellite services, families are referred either a few months prior to the child's return home or after re-entry. In these families our treatment approach is to normalize the child's environment as quickly as possibly (i.e. arrange for schooling, medical care, basic needs) and to help the entire family discuss the implications of the child's behavior and fear of rejection. Focus is placed on historical issues that resulted in placement, and current concerns associated with the child's return home.

Services are as comprehensive or as specific as the family's needs dictate. Satellite services include the following:

Direct Services

- crisis intervention on a 24 hour basis
- individual counseling when indicated
- group counseling when indicated
- adjunctive task oriented homemaker services to assist in house and family care
- financial planning
- maintenance assistance
- agency coordinated recreation
- food assistance through the Greater Chicago Food Depository
- diagnostic and assessment service
- individualized educational program planning
- social work services
- assistance with job finding and placement
- first aid education to parents and children
- sex and drug education
- nutritional consultation

Collateral Services

- liaison to community health services
- consulting nurse, psychologist, psychiatrist, and physician
- liaison to community mental health services
- liaison with public schools
- liaison with occupational development centers
- work training support with community employers
- liaison with court services

Case Planning and Review. Services begin at admission and treatment planning includes a standard ninety day assessment of the family's functioning. Formal treatment planning conferences are held at six month intervals thereafter. Teams update treatment plans a minimum of once per month. Satellite staff actively participates in Administrative Case Reviews and in treatment planning done with other agencies and the courts. Caseworkers are kept informed of the latest developments in all families via incident report and other frequent contact.

Family Workers' Role. The primary role of treatment staff is that of non-judgmental friend of the family. Staff actively seek to develop such a relationship with all members of the client system, and seek to use this relationship to help the family improve its functioning. Most service occurs in the family's home or community, and includes counseling, advocacy, basic services and activities approaches. Other treatment techniques include role-modeling, individual and family counseling as well as group treatment. Stipulations placed by other agencies (courts, DCFS) are seen as tools for change. Sixty percent of the 80 - 120 hours of service per month is spent in face to face contact with the families. In addition, many hours are devoted to advocating with collateral agencies (schools, courts, hospitals, public agencies,) coordinating support services and advancing the family's best interests.

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Therapeutic Foster Family Programs

Kaleidoscope, Inc.'s Therapeutic Foster Family Programs provide family living and specialized services to children and youth who otherwise would be placed in institutions. The program is specifically designed to serve those considered the most difficult-to-place -- severely troubled youth who have experienced many previous placements, institutionalized kids, children and youth with severe mental illness or multiple handicaps, troubled youth who are pregnant or parents and children who are medically fragile and affected by AIDS (HIV). All children and youth in this program are wards of the State, referred by the Department of Children and Family Services (DCFS). The program is supported by purchase of service agreements with DCFS and has received some private grant support.

Kaleidoscope's therapeutic foster care is markedly different from most foster care programs in which foster parents care for children temporarily until they can return home or be adopted. For most of our children, adoption or returning home is not a viable option. The major goal of our Therapeutic Foster Family Programs is to provide unconditional care for our children -- to keep them in our care regardless of the difficulty of their behavior or needs. Unconditional care, we believe, is vital to breaking the cycle of repeated failures and rejections our children have experienced in their own families and in previous placements. Many of our children have never had parents capable of meeting their most basic needs. Their self-esteem has suffered tremendously because of this lack of nurturing and repeated rejection, and most of our children view themselves as "born losers." We seek to provide them with foster families who will give them acceptance, structure and nurturing, so that they can begin to cast off their negative self images and become healthy competent people.

The heart of the Therapeutic Foster Family Programs is clearly our professional foster parents. These parents are carefully recruited, trained, licensed, and paid to work as foster care professionals with the children they accept into their homes. We require that one foster parent in each family be available on a full-time basis to care for the child placed in their home. Therapeutic Foster Family Programs staff confer with foster parents at least weekly to provide supervision, support, and assistance in securing specialized treatment services.

Unlike most foster family care, Therapeutic Foster Family homes are not just places for children to live until they can go back home. Therapeutic Foster Family Programs provide specialized care so that children and youth can stay out of institutions, learn to live in families, and, in the case of our adolescent parents, learn to become effective family heads. A few children in the Therapeutic Foster Family Programs do go back home, but most will either stay in foster care throughout their minority or enter the Youth Development Program so that they can learn to live on their own.

Service Philosophy

Therapeutic Foster Family Programs are one of an array of services provided by Kaleidoscope, a not-for-profit, child welfare agency, licensed by the State of Illinois, that serves children and youth considered most-in-need and otherwise destined for institutional placement. Therapeutic Foster Family Programs thus embrace the agency's mission and philosophy of serving children and youth, as follows:

- To serve children regardless of the severity of their behavior problems, emotional disorders, handicaps, or medical conditions.
- To ensure that children and youth should not be denied the experience of family and community life.
- To help children, youth and their families live as normally and be as self-sufficient as they possibly can.
- To help children by helping their families.
- To help older youth learn to become self-sufficient, whether they live with families or not.
- To advocate for better policies and programs for children who are considered to be most-in-need.

Program Management

Therapeutic Foster Family Programs serve over 70 children and youth referred from DCFS, including adolescent parents and their infant children, and infants suffering from Human Immune Deficiency Virus (AIDS). All foster parents are licensed by DCFS. Foster parents are recruited, trained, and licensed under the direction of the Program Services Coordinator, a specialist in these tasks. Foster parent supervision and support is provided by teams of Bachelors and Masters Degreed Social Workers. These staff teams also provide casework and clinical services to the children and youth. In all, teams provide a minimum of one foster home visit per week and a minimum of 10 hours of direct contact with foster parents, clients, and biological and extended family members. Additional agency support is provided by a Vocational Counselor, a therapeutic Recreation Specialist, and agency administration. Typically, only one child is placed in a foster home, although sometimes two children will be placed in one home if they are siblings. In the case of the Adolescent Parents Program, one family unit (adolescent parent and child\ren) is placed in each foster home.

Professional Foster Parent Recruitment and Training

Foster parents are recruited through the mass media (newspaper ads, public service announcements, and the like), but most come to us by word of mouth -- one of their friends, neighbors or parishioners has been a Kaleidoscope professional foster parent or staff member. Our foster parents must be able to make a strong commitment to taking a seriously emotionally unique child into their home, and they must be willing to accept this child as part of their own family on a long-term, no-decline basis. Prospective foster parents are trained to expect misbehavior and testing from their foster children, who have learned by experience to try to evoke abuse and rejection. Kaleidoscope promotes a positive approach to parenting, focusing on building children's self-esteem and maintaining realistic expectations. Foster parents must complete a formal, structured pre-service training course before accepting children into their homes, and they must participate in regularly scheduled in-service training classes thereafter. They also receive less structured in-service training and support from agency staff and from other foster parents.

Therapeutic Foster Family Programs -- Service Delivery

Service Goals: The service goals in common to all children and youth in the Therapeutic Foster Family Programs are to: stabilize their behavior, learn to live with families in the community, and keep them out of institutions. Additional treatment goals are to: promote self respect and maturity by building self-esteem, provide structure and limits to encourage responsibility and control, help resolve trauma from loss and separation, provide role models, and teach alternatives to misbehaving.

Service outcome goals vary. Whenever appropriate, Kaleidoscope will reunite children with their birth parents or place them for adoption. More frequently, we will plan to "graduate" youth from this program into our Youth Development Program so that they can learn to live on their own. But most often, we will try to stabilize children in our foster homes so that they can remain there throughout the remaining years of their childhood. Many of these kids "age out" of Therapeutic Foster Families Programs when the State releases guardianship and thus is no longer financially responsible for their care. In many cases, the foster family becomes the "permanent" family, the people on whom our youth can continue to lean when they become adults. In other cases, Kaleidoscope staff become this source of support. A few handicapped youth will "age out" of the Therapeutic Foster Family Programs' care and into sheltered living facilities. Others do not live with, but restore ties to biological families members. Some of the terminally ill infants and children in STAR (Specialized Team for AIDS Relief) are able to live out their short lives in the loving environment of the foster home.

Services Provided:

Professional foster parents provide:

- a nurturing, family environment
- 24 hour supervision
- discipline that encourages responsibility and caring
- transportation of youth to activities and appointments
- participation in the children's school and community activities
- advocacy on behalf of youth
- role modeling and parenting education (Adolescent Parents Program)

Agency provides to professional foster parents:
- orientation and training
- formal supervision and support, including a minimum of one home visit per week
- emergency consultation and crisis intervention on a 24-hour basis
- in-service training
- compensation

Agency provides to biological family:
- inclusion, when appropriate, in treatment planning
- planning and supervising visits, when appropriate
- referral, when appropriate, to the Satellite Family Outreach Program

Direct agency services to children and youth:
- treatment planning
- casework services including a minimum of two treatment sessions per month
- individual, group, or family therapy, by qualified therapists, as needed
- planning and supervising visits with birth or extended family
- educational planning
- vocational assessment and job services
- recreation

Collateral (secure or refer) agency services to children and youth:

- liaison with schools or other educational resources
- liaison with employers or job training programs
- secure specialized clinical services
- secure routine and specialized medical treatment
- secure dental and eye care
- liaison with churches, youth groups, and other community resources
- day care (Adolescent Parents Program)
- prenatal and neonatal care (Adolescent Parents Program, STAR Program)

Case Planning and Review: The Therapeutic Foster Family Programs use a team approach to carry out individualized treatment plans. The Social Worker (usually Masters Degreed) serves as case manager to coordinate planning and treatment for each child. The Foster Family Worker (Bachelors Degreed) and Foster Care Team Supervisor (Masters Degreed) are the main direct services contacts for the child, the foster family, and the biological family, and thus have some responsibility for carrying out, as well as monitoring the treatment plan. The professional foster parents also have responsibility for adhering to the treatment plan and maintaining records on the children's progress.

Treatment planning begins at admission, with a formal assessment of the child's strengths and weaknesses and a careful matching of child and foster family. The initial staffing takes place upon admission, and formal treatment planning conferences are held at three month intervals. Teams update treatment plans a minimum of once per month. Staff and foster parents actively participate in DCFS Administrative Case reviews and in treatment planning done with other agencies and the courts. DCFS caseworkers are kept informed of the latest developments in all families via unusual incident reports and other frequent contact.

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Youth Development Program

Service Philosophy

The Youth Development Program is one of an array of services provided by Kaleidoscope, Inc., a child welfare agency, licensed by the State of Illinois to serve children and youth considered most-in-need and otherwise destined for institutional placement. The Youth Development Program embraces the agency's mission and philosophy of serving children and youth, summarized as follows:

- To serve children and youth regardless of the severity of their behavioral problems, emotional disorders, or handicaps,
- To ensure that children and youth are not denied the experience of family and community life,
- To help children, whenever possible, by helping their families,
- To help older youth learn to become self-sufficient.
- To advocate for better policies and programs for children who are considered to be most-in-need.

Kaleidoscope, Inc.'s Youth Development Program helps older, severely troubled youth in the child welfare system, learn to live on their own. These youth typically have been in the system for years and have lived in many different foster homes and residential treatment programs. They will not be adopted, and they cannot live with their biological families. Although they first came into care because they were abused or neglected as young children, most have developed severe behavioral problems over the years. Some have other physical or mental handicaps as well.

Nevertheless, they will soon be too old to be state wards and must be able to make it on their own when the Department of Children and Family Services (DCFS) terminates guardianship and service support. Kaleidoscope, Inc. specifically seeks to serve these older wards considered to be the most difficult to help. Our Youth Development Program serves older teens who have not demonstrated a readiness for independence. It is a program of last resort -- one that serves youth who have not adjusted in other kinds of programs.

Youth Development Program staff help youth to: live on their own in apartments, take care of themselves, monitor their own behavior, find friends and family to lean on, and find and keep jobs. In addition, staff provide intensive supervision. The agency secures apartments for them and provides a modest stipend to cover their living expenses. The agency also provides or arranges for medical care, therapeutic recreation, and individual and group therapy. Most of the youngsters in the Youth Development Program are referred by the Department of Children and Family Services. The program is supported by purchase of service agreements.

Youth Characteristics

Most youth in the Youth Development Program are ages 18 or 19; a smaller number are 17 or 20. Occasionally a 16 year-old is admitted. Fifty percent of the youth are adolescent parents who are also caring for their own children. Youth in the program have had an average of eleven previous placements in the child welfare system; the range of previous placements is one to twenty-nine. They are referred to us for primarily "behavioral management problems," a vague label that often masks serious emotional and developmental disturbances, and one that simply means other programs have not been able to reach them.

Typically, youth in the Youth Development Program have been physically or sexually abused. All are far behind in school, and many are functionally illiterate... most lack work habits, skills, and experiences. Some still have connections with their biological families, even if they cannot live with them. But for most, especially those who have grown up in the foster care system, family ties have long ago been severed. Many have had frequent skirmishes with the law. Drug and/or alcohol abuse is common among this population. Perhaps the major problem that we must help these youth overcome is one that is both the cause and the consequence of all their other problems -- extremely low self-esteem. Self-esteem so low that these youth expect to fail and often try to self-destruct.

Program Management

The Youth Development Program currently serves 44 youth. Clients are supervised and served by two staff teams. Each team consists of three bachelor's degreed Youth Workers, one Youth Worker Supervisor, one Adolescent Parent Specialist and two Mastered Degreed Social Workers. Each team serves up to 22 youth. Youth workers provide the range of direct and collateral services, and the Social Workers provide clinical consultation and services. Additional agency support is provided by a therapeutic recreation specialist, a job services specialist, a housing specialist, and agency management. Only one youth is placed in each apartment. Staff provide at least 10 hours of direct contact per month with each youth, which includes at least four home visits per month. In addition, each youth visits the agency at least once a week to pick up their living allowances and to meet with staff.

Service Delivery

Service Goals. The service goals common to all youngsters in the Youth Development Program are to: stabilize their behavior, teach them to live on their own in the community, help them become self-supporting to the maximum extent feasible, and keep them out of institutions. Service outcome goals vary. Some youth will learn to live in the community and be entirely self-sufficient. Others will live in sheltered living facilities. Some will live with, but not be dependent upon, friend or family. A few will require continuing state support for their severe handicaps and other disadvantages which preclude their becoming entirely self-sufficient by the age of 21.

Services Provided. The type and amount of service received by each youth in the program is determined by their individual needs. The agency is committed to providing as much, but not more, help each youth needs in order to achieve his/her goals. The following services are made available to youth in this program:

Direct Services

- an apartment in a residential neighborhood
- casework services
- formal, regular supervision
- crisis intervention on a 24 hour basis
- advocacy with courts, school, etc.
- therapeutic recreation
- individual counseling/psychotherapy
- group counseling
- educational program planning
- vocational assessment
- job development
- sex and drug education
- independent living skills development

Collateral Services

- liaison with schools and education resources
- liaison with employers and job training programs
- liaison with courts
- liaison with specialized clinical professionals
- liaison with the Department of Public Aid
- secure medical treatment
- secure dental, eye care

Case Planning and Review. Treatment planning begins at admission, with a careful assessment of the youth's strengths and weakness. Formal treatment planning conferences are held at six month intervals thereafter. Teams update treatment plans a minimum of once per month. Staff actively participate in DCFS Administrative Case Reviews and in treatment planning done with other agencies and the courts. DCFS caseworkers are kept informed of the latest developments with all youth via incident reports and other frequent contact.

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December, 1992

Definition of WrapArounD

A wraparound intervention is developed and/or approved by an inter-disciplinary services team, is community-based and unconditional, is centered on the strengths of the child and family, is culturally competent, and includes the delivery of coordinated, highly individualized services in three or more life domain areas of a child and family.

An inter-disciplinary services team, at a minimum, includes: 1) The parent and/or surrogate parent (i.e., foster parent or guardian); 2) If the child is in custody, the appropriate representative of the state (social worker or probation officer); 3) A lead teacher and/or vocational counselor; 4) If the child is in mental health treatment, or should be in mental health treatment, the appropriate therapist or counselor; 5) A case manager or services coordinator (a person who is responsible for ensuring that the services are coordinated and accountable), 6) An advocate of the child and/or parent; and 7) Any other person influential in the child's or parent's life who may be instrumental in developing effective services, such as a neighbor, a physician, a relative, or a friend. In addition, the child should be included on the team unless to do so would be detrimental to the development of the child.

Community-based means in the local community or rural area where the child and his/her family live. Restrictive or institutional care should be accessed for brief stabilization only.

Unconditional care means that the team agrees to never deny services because of extreme severity of disability, to change services as needs of the child and family change, and to never reject the child and family from services.

Strengths of the child and family mean that the positive aspects of the child, family and community must be considered and be part of individualized services.

Individualized services are based on specific needs of the child and/or family, and not on a particular categorical intervention model. These individualized services are both traditional (therapy; foster care; etc.) and non-traditional (hiring a special friend; bringing staff to live in a family home; special recreational services, etc.) Traditional services should be accessed only when they can be tailored to the specific needs of the child and family.

Life domain needs are areas of basic human needs that almost everyone experiences. These are: 1) Residential (a place to live); 2) Family or surrogate family; 3) Social (friends and contact with other people); 4) Educational and/or Vocational; 5) Medical; 6) Psychological/Emotional; 7) Legal (especially for children with juvenile justice needs); 8) Safety (the need to be safe); and other specific life domain areas such as cultural/ethnic needs or community needs.

Cultural competence means that services need to be designed and delivered which incorporate the religious customs, regional racial and ethnic values and beliefs of the families we serve.

Appendix F
Partners Project

Linn County Youth Service Teams information provided by the project.

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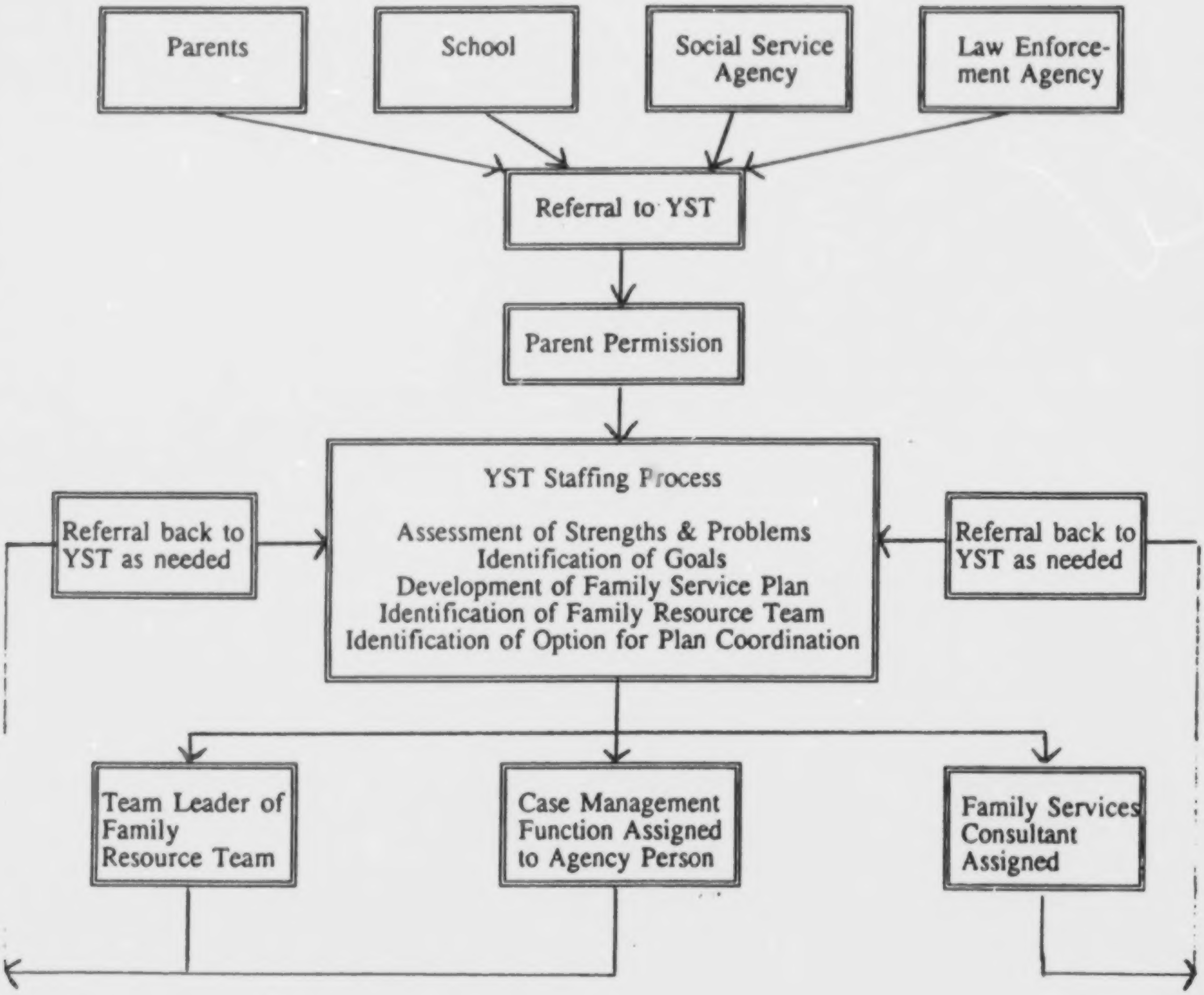
YOUTH SERVICES TEAM GUIDELINES AND PROCEDURES

YOUTH SERVICES TEAM MODEL


Parents
School
Social Service Agency
Law Enforcement Agency
Referral to YST
Parent Permission
Referral back to YST as needed
YST Staffing Process
Assessment of Strengths & Problems
Identification of Goals
Development of Family Service Plan
Identification of Family Resource Team
Identification of Option for Plan Coordination
Referral back to YST as needed
Team Leader of Family Resource Team
Case Management Function Assigned to Agency Person
Family Services Consultant Assigned

The Youth Services Team model, as shown above, begins with pre-referral activities where the referral is completed and parents are invited to participate. The child or youth referred is then staffed at the Youth Services Team and a plan is developed and follow-up activities are provided. An option for service coordination is determined.

Oregon Department of Education. (1989). *A resource guide for Oregon educators on developing student responsibility*. Salem: Oregon Department of Education.

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A Resource Guide for Oregon Educators on Developing Student Responsibility

1989

Division of Special Student Services
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Introduction

Purpose

One of the objectives of the Oregon Department of Education is to work with public schools in their efforts to assist students to (1) achieve maximum development of individual knowledge, skills and competence, and (2) learn and use behavior patterns which are characteristic of responsible members of society.

This publication has been prepared to aid educators in understanding how to effectively encourage and facilitate responsible student behavior. The Resource Guide goes beyond constitutional and mandated procedures and includes suggestions for research-based and educationally sound practices. The major focus is the development of a comprehensive and consistent approach to:

- encouraging conditions that promote responsible student behavior and thereby decrease student behavior problems;
- teaching students responsibility and self-discipline;
- maintaining a proactive rather than reactive response to students who exhibit irresponsible behaviors; and
- balancing the rights of students in order to maximize academic and social growth.

This document is not intended to comprehensively address every component, but rather to provide a framework to address responsibility in a comprehensive way.

Philosophy

Student responsibility and self-discipline can be facilitated and learned in the school environment, regardless of existing negative influences in a student's life. The following principles, when combined, provide a framework and philosophical basis for this publication.

- A positive educational approach emphasizing problem prevention and effective teaching is of major importance in creating responsible student behavior.
- Equally important is an emphasis on classroom and schoolwide efforts to teach students the skills necessary for positive behavior and development of student responsibility.
- Maintaining an integrated, comprehensive, systematic and consistent approach by school staff to encourage and facilitate student responsibility maximizes opportunities for success.
- Managing student behavior is a proactive process which is designed, implemented and monitored in a way to include consideration of instructional factors, curricula, relationships, services and settings[8].

By focusing on problem prevention and teaching students alternative ways to behave and meet their needs when they do exhibit behavior problems, schools will achieve a high degree of responsible student behavior and dramatically reduce the level of discipline problems in their student bodies.

A Continuum of Services for Managing Student Behavior — Interventions

One of the most important components for encouraging student responsibility is a process providing increasing educational interventions if students continue to demonstrate irresponsible behavior. Built into the process should be the essential and unrelenting question: "*What additional skills do students need in order to develop responsibility, and what level of educational interventions are necessary to facilitate such learning?*" Such a process offers a much greater chance of success than merely allowing a student to face negative consequences over and over again for irresponsible behavior.

A Continuum of Services is a systematic framework. It encourages student responsibility and the management of student behavior through a preventive, problem-solving process that allows for appropriate provision of services for all students[6]. Such a continuum is shown on the chart on page 5. This continuum both prescribes the level of services needed to encourage students to behave in a responsible manner and describes where students are in terms of their educational placement in an environment where they can reach their maximum potential. The placement should take into account educational, social, cultural and handicapping conditions. Movement of students on the continuum beginning at Step 1 and culminating with Step 5, reflects their progressive need for increased interventions.

How the Continuum Functions

The process begins at Step 1 with the use of basic school resources to serve the entire student population. With appropriate classroom processes in place at Step 1, fewer students will need Step 2 services and interventions. For those students who engage in behaviors that interfere with their learning or the learning of others, Step 1 procedures, involving classroom adjustments designed primarily by the teacher, are made. If students continue irresponsible behavior, they move to Step 2 which results in building resources being utilized for educational interventions. Such a process continues with Step 3 utilizing district resources, Step 4 with eligibility for and provision of special education services, and ends with Step 5 which includes maximum utilization of resources: special education, district resources and community resources in a student's educational plan.

Benefits of the Process

The overall benefits of having a full continuum of services available is that it:

- Provides a clear process for educators to use in identifying student needs and responsive school services in a timely and effective way.
- Facilitates the development of a behavior management plan that "matches and incorporates the unique characteristics of both students and school services"[7].
- Allows educators to serve the maximum student population with a minimum number of services and to serve a minimum number of students with a maximum level of resources.
- And ensures that students are consistently educated in the least restrictive environment, thus preventing over-identification of students as Seriously Emotionally Disturbed.

A Continuum of Services for Managing Student Behavior

Step	Responsibility	Placement/Procedure	Primary Processes
1	Classroom teacher	Regular classroom placement	a) Examination of instructional, curriculum and teaching methods b) Examination of social/cultural factors c) Classroom management process d) Teacher intervention and modification of above, as needed e) Consultation with parents
2	Classroom teacher and school staff	Regular classroom placement and referral to school resources/school discipline system	a) Team problem-solving process focused on casual factors and services needed b) Schoolwide Student Management process c) Review of Step 1 processes
3	Classroom teacher, school and district staff	Regular classroom placement or alternative educational program and request for district resources	a) District/building team process for developing written behavior plan with student b) Coordination of behavior plan by specified staff member c) Review of Step 2 processes
4	Classroom teacher, school and district staff	Request for special education evaluation. Placement in a special building program and/or regular classroom	a) Team process to determine eligibility for special education b) If eligible, IEP team process to determine placement and program c) If ineligible, return to Step 3 processes
5	School staff including special education	Placement within district resources and referral to community resources	a) MDT process to evaluate continuing need for special education b) IEP process to plan services and review continued need for restrictive educational placement

tinually strive to utilize teaching and instructional methods that address student's personal and academic needs, promote student involvement in a variety of learning activities, facilitate on-task behavior and enhance student motivation. For students who are experiencing frustration and failure, or who are exhibiting behavior problems in the classroom, it is important that the curriculum and instructional strategies be closely examined and modified as needed.

In evaluating the curriculum and instructional approaches, the following questions may be helpful. This list reflects important considerations which may have a major impact on promoting or discouraging student responsibility and which frequently get overlooked in working with students who demonstrate inappropriate behavior.[12] This list is not meant, however, to be comprehensive in terms of all instructional considerations.

1. Is instruction matched with the student's learning style and cognitive abilities?
2. Is the student given realistic and immediate feedback on academic work and being retaught information the student has not yet mastered?
3. Is the student involved in academic goal-setting so that success is experienced?
4. Does the time required for individual seatwork take into account the student's ability to complete the assigned work?
5. Is there relevance of the subject matter to the student's personal life and does the student understand this connection?
6. Are necessary teaching modifications being provided to meet the student's individual needs (i.e., changing the way the student gets the information, altering assignments, altering lessons, changing the way student feedback is given or adjusting the evaluation procedures)?
7. Does the grading system motivate the student to make an effort in school work?
8. Is the student receiving more positive than negative feedback?
9. Are the student's needs for security, safety, belonging, affection and self-respect being met within the classroom environment?
10. Are there outside environmental factors which may be interfering with the student's fulfillment of personal needs for which a referral for help is necessary?

Examining Organizational Factors: The following questions serve as a guide to examining some key organizational factors:

1. Is instructional time used effectively?
2. Are students placed in instructional groups which fit their instructional needs?
3. Do the transitions between instructional activities promote positive student behavior?
4. Is the classroom designed to facilitate on-task behavior?
5. Is seatwork time used effectively?
6. Is pacing effectively used to balance information and student involvement?
7. Is student feedback and evaluation effectively utilized to maximize student success and responsible behavior?

Examining Social Factors: The social atmosphere or climate of the classroom can promote positive student behavior and self-responsibility. A classroom climate most conducive to encouraging positive student behavior is one which:

- Allows students to feel safe and accepted as persons of worth and dignity,
- Is based on mutual respect and cooperation,
- Promotes understanding of self and others,
- Provides respect for individual uniqueness, and most importantly,

4. Do culturally diverse students have sufficient linguistic proficiency to engage in and benefit from adult and peer interactions?

5. Do the instructional and teaching strategies take into account each student's preferred learning modes, including:

   a. a language preference,
   b. a preferred way of relating to others,
   c. an incentive preference, and
   d. a preference for thinking, perceiving, remembering, and problem-solving[19]?

Establishing a curriculum that accommodates the unique learning style of all students, including those who are culturally different is essential. Howard[20], summed up "multicultural education" by stating:

> It is not simply a recognition of holidays, goods, histories, and role models. It is an appreciation of diversity in cultural values, nonverbal behavior and meanings, and cognitive styles. Our goal, as educators, should not be to help everyone succeed in the same way, but to help everyone succeed in ways that best reflect their own unique, individual and cultural styles and values.

Examining the Classroom Management System: Research studies on teacher effectiveness and classroom management support the need for the development of a proactive classroom management process aimed towards self-discipline and student responsibility.[21] The traditional methods of improving student behavior relies on telling students how they should act, how they should feel, what is right from wrong and methods used to "control" student behavior. A proactive approach moves towards providing students with the opportunity to actively explore their attitudes, thoughts, emotions, behaviors and concerns for themselves and others so that they learn to make appropriate and responsible behavioral decisions.

The following factors have been present in classrooms with effective student management systems:

- The emphasis is on positive student behaviors and preventive measures.

- Problem-solving is focused on causes of behavior problems rather than symptoms.

- Students are involved in resolving behavior problems through a problem-solving process.

- Expected student behaviors are taught and clearly articulated.

- Teachers model desired student behaviors[22].

The process of examining the classroom student management system requires a focus on (1) classroom rules and (2) consequences for meeting or failing to meet such rules. Both are essential components of a student management system.

Classroom Rules: Research has revealed that student behavior is more constructive, consistent and reflective of what the teacher expects in the classroom when students understand exactly what is expected of them.[23] In examining effectiveness of classroom rules, the following questions may provide assistance:

1. Are the rules developed with student input and participation?

2. Are they stated positively in terms of what students are expected to do rather than what they are not supposed to do?

3. Are they clear, easy to understand and in fact, understood by all students?

4. Are they written and posted in a visible place in the classroom?

5. Are they consistent with the building's code of conduct or student management plan?

6. Are they related to responsible behavior to self and others and to maintaining a classroom environment conducive to learning?

Classroom Consequences: It is imperative for students to understand and be able to predict

- critical thinking,
- problem solving,
- decision making,
- communication skills, and
- various other social skills.

The following questions address key factors in teaching student responsibility.

1. Is teaching directed towards helping students understand their individual rights and responsibilities to others?
2. Is training provided in cooperative problem solving and decision making?
3. Are students retaught what is responsible behavior when they demonstrate behavior that falls outside the limits of what is expected?
4. When students exhibit behavior problems in the classroom, are efforts made to clarify the underlying problems which led to the behaviors and then teaching alternative and appropriate ways of dealing with such difficulties?

Students often exhibit disruptive behavior "*as a way to reduce feelings of frustration, tension or anxiety*"[26]. They must be provided with instruction designed to assist them in understanding their own behavior and then learn appropriate ways to get their needs met. Punishing students for inappropriate behavior will not teach them alternative and more appropriate ways to manage their emotions.

Step 2: Referral Activities with Building Resources

Process and Procedures

Entry Criteria: If a student continues behaviors that interfere with ability to make educational progress following implemented interventions at Step 1 or if a student exhibits inappropriate behaviors which results in automatic referral into a school's management and discipline system, Step 2 procedures are implemented.

Primary Responsibility: The regular classroom teacher and building staff share responsibility at this step. The student maintains placement in the regular classroom.

Procedures:

1. The classroom teacher addresses the student's problem behavior with other school staff within the building who may be able to provide assistance; i.e., other classroom teachers, consulting teachers, counselors, school social workers, child development specialists or principal.
2. The team plans intervention efforts and those responsible for managing the student direct the intervention.
3. A referral into a schoolwide student management system is made if the student exhibits behaviors identified as unacceptable for which consequences are specified.
4. Referrals to community agencies are made, as needed.

Often Step 2 students are involved with other community agencies, i.e., Children's Services, Mental Health, Juvenile Department, local law enforcement agencies, etc. Some schools are engaged in a Youth Services Team Model in which school and agency staff collaborate in team problem solving to plan effective interventions for students. While school and agency collaboration often begins at Step 2, it can occur at any step within the continuum.

Exit Criteria: If the Step 2 interventions are effective in assisting the student in making

- Encourage students to assume responsibility for their academic and behavioral choices by clarifying their rights and responsibilities, expectations or rules for responsible behavior, and consequences for meeting or violating the rules, and

- provide a consistent school staff response to students requiring behavioral intervention.

Minimum components found in such policies include the following:

- student rights and responsibilities,

- rules of conduct or behavioral expectations,

- disciplinary responses for rule violation of specified behaviors, and

- regulations for procedural due process involving suspensions and expulsions.

One of the components consistently found in schools with effective management processes is a Schoolwide Student Management Policy that includes a proactive educational approach to encourage responsible behavior and prevent discipline problems. In such schools, student learning considerations are the major criteria used in decision making[27]. Educational interventions are provided when problems develop. Such an approach is based on the recognition that more is required than merely attempting to deal with student misbehavior or reducing discipline problems through punishment procedures[28].

The following key questions are provided to assist educators in reviewing their policy in terms of its educational approach and focus on encouraging responsible student behavior.

1. Is the policy developed by involving educational and support staff, students, parents and community members?

2. Does the policy respond to the unique behavior management needs of the building and local community?

3. Is the policy understood by educational and support staff, students and parents through training efforts?

4. Is the policy reviewed at least on an annual basis by participants in order for it to reflect current building needs, community attitudes and changing laws?

5. Do each of the rules within the policy have a legitimate and rational relationship to the school's stated educational purpose?

6. Are disciplinary actions for rule violations educationally sound, commensurate with the student's inappropriate behavior and compatible with the student's needs?[29]

7. Are disciplinary actions coupled with educational interventions and problem-solving processes to encourage responsible behavior?

8. Is there a distinct discipline policy for handicapped students which insures legal protections such as prevention of exclusionary discipline for behaviors related to a student's handicapping condition?

Step 3: Documented Plan with District Resources

Process and Procedures

Entry Criteria: If a student continues behaviors that interfere with their ability to make educational progress following Step 2 interventions, movement to Step 3 may be decided upon by the educational and building team members. Step 3 procedures related to "Alternative Educational Programs" (AEP) will automatically occur, as required by ORS 339.250(6) and OAR 581-21-071, in the following circumstances:

- Upon the occurrence of a second or any subsequent occurrence of a severe disciplinary problem within a three-year period;

3. The student is then placed in an AE program.

(For further information on the development of AE programs, the reader is encouraged to review Oregon Department of Education's Technical Assistance Manual on Alternative Educational Programs.)[30]

4. **Exit criteria:** At the end of the semester, contract period with an AE program, or at the end of an expulsion period, the team must assess whether the behavior problems have improved to allow the student to make educational progress. If the student's behavior has improved, the team decides whether to continue the AE program (with parental approval) or recommend the student return to the regular education program with appropriate level interventions. If the behaviors continue to interfere with the student's educational progress, the team determines whether to try alternative Step 3 procedures or move to Step 4.

Evaluating Effectiveness of Primary Processes at Step 3

Development of a Personal Educational Plan (PEP):

1. Are the student, staff responsible for managing the student, and parents included in the development of the plan?
2. Are expectations for responsible student behavior, consequences for responsible behavior, and consequences for irresponsible behavior clearly stated in the plan, understood by all and consistently enforced?
3. Are the teaching of necessary social skills included in the plan with opportunities for the student to practice problem solving?
4. Is the plan utilized as a process to encourage responsible student behavior by periodic reviews between student, staff, and parents in order to make modifications in the plan as needed?
5. Is documentation being maintained during this intervention phase to show student behavior response to the plan?
6. Are building and district support services being utilized to maximize potential student progress?

Development of an Alternative Educational Program (AE):

1. Are the proposed alternative programs based on the student's learning styles and needs?
2. Are the proposed alternative programs consistent with the student's educational and vocational goals? (i.e., do the programs offer credits leading to high school graduation if the student wants to pursue graduation?)
3. Is an assessment process following placement in an alternative program built in to address whether the program is successful in allowing the student to make educational progress?
4. Are the proposed alternative programs discreetly different from the student's regular education program?
5. Are the proposed alternative programs available and accessible to the student?

Consequences for Responsible Behavior
- Acquiring friends
- Enjoy recess and lunch time
- Stay in class with friends
- Feeling positive about yourself
- Getting off this PEP if followed for four weeks

Irresponsible Choices (choosing negative consequences)
- Start yelling
- Fighting, shoving, hiting, kicking, spiting, pushing or hurting kids
- Cussing, verbalizing obscenities
- Break class and school rules that I don't agree with or because I'm upset

Consequences for Irresponsible Behavior
- Teacher will give one warning to student to make a different choice.
- If inappropriate behavior continues, student is expected to go to the office to fill out a Problem-Solving Form and then meet with the vice-principal before returning to class.
- Regular classroom and student management procedures for all students will be followed in addition to above.

Expectation 2: Complete Academic Work

Responsible Choices
- Listen and participate by showing eye contact, responding to questions, and following class activities.
- Begin work immediately by listening to directions, getting out necessary materials, and beginning assignment.
- If work is difficult, keep trying or ask a teacher for help.
- If bothered by others, move to a quiet place in the room.
- Write all assignments on assignment sheet and take home for parent review.
- Have teachers initial assignment sheet for completed work.

Consequences for Responsible Behavior
- Finish work on time and get better grades.
- Stay in class with friends.
- Have more free time in evenings and weekends.

Irresponsible Choices
- Continual talking to others or just gazing around.
- Trying to get others attention by making noises or gestures.
- Playing with things in the desk.
- Giving up when the work is difficult.
- Forgetting to keep assignment sheet current or forgetting to being it home.

Consequences for Irresponsible Behavior
- Teacher will give one warning for off-task behavior.
- If behavior continues, student will move to back of room to work.
- If work is left incomplete, student will use next recess time to complete work.
- If work still incomplete at end of recess, it will become homework.
- Parents will check assignment sheet daily and student will get free time at home following work completion.

Step 4: Referral for Special Education Services

Process and Procedures

Entry Criteria: If Step 3 interventions have been unsuccessful and the behaviors continue to interfere with the student's ability to make educational progress, the team may decide to move to Step 4 for determination of special education eligibility.

Primary Responsibility: The regular classroom teacher, building staff and district resource staff are all utilized at this step. The MDT determines eligibility, the Individualized Educational Program (IEP) team determines the programming and placement and the special education staff provides the coordination of services.

Procedures:

1. Procedures begin with a referral to special education. Ongoing Step 3 interventions are continued during the MDT's *determination of eligibility*.
2. The MDT process includes conducting an evaluation upon parental approval, determining student needs and determining a student's eligibility as handicapped (Seriously Emotionally Disturbed [SED]) according to established federal and state regulations.
3. Following an eligibility determination, the IEP team develops an appropriate educational program. The student's placement is within building resources determined by "least restrictive environment" regulations.

Exit Criteria: If the IEP team determines that an educational program requires a student's placement in district resources combined with the provision of community resource services as well, movement to Step 5 is indicated.

Step 5: District Placement with Community Resources

Process and Procedures

Entry Criteria: This is the same as exit criteria for Step 4.

Primary Responsibility: School staff, special education and other district staff and community resource staff all share responsibility at this step. Responsibility for oversight of the student's educational plan rests with the IEP team.

Procedures:

1. The IEP team determines an appropriate placement within district resources or community resources through a contractual arrangement with the district. State resources such as private education programs from the "Christie List" may also be utilized at this step.
2. A referral for community resource involvement is made, unless already arranged at a previous Step.
3. Implementation of the IEP is managed by the coordinator named by the team.
4. Direct and indirect regular or special education services as specified in the plan are provided to the student in the least restrictive educational environment feasible.

Exit Criteria: If the interventions applied have been effective in assisting the student in making educational progress, the IEP team determines whether to continue the Step 5 intervention or return to a lower level of intervention with placement in the least restrictive environment expected to maintain a student's educational progress. If the intervention has not been effective, the MDT may be called upon to develop a new assessment plan to collect data for the IEP team's development of an alternative IEP.

The principal makes it happen by being a visible force in promoting school expectations for good behavior, facilitating student-teacher problem-solving activities, emphasizing a student-centered approach to the curriculum and instruction, and by intervention activities that utilize the reinforcement power inherent in the position.

Training Staff: Active involvement of staff in all of the implementation steps increases their ownership for, commitment to, and responsibility toward improving student behavior. It is therefore essential for all staff to receive training on the processes and components of providing a continuum of services and to gain a working knowledge in the application of research-based effective practices to encourage student responsibility.

Assessing Current Building-Student Management Processes and Practices: To maximize improvement efforts, it is necessary to understand what is actually taking place in the school so that strengths and areas needing improvement can be clarified. Staff, student and parent input is recommended and can be obtained through a variety of methods. The questions related to effectiveness which are addressed throughout this document can be utilized as a guide in this assessment process. Such questions explore schoolwide practices including but not limited to:

- Instructional practices and curriculum
- Policy guidelines and discipline practices
- Expectations for positive student behavior
- Parent and community involvement in the school
- School climate

In addition, exploring the current levels of student performance, academic achievement, attitude towards school, and behavior, can be valuable in identifying areas needing improvement. Exploring the underlying causes of identified student behavior problems in the school can also clarify school responses which may facilitate student improvement.

Goal-setting: Improvement efforts are most effective when there is a focus placed on one or two high-priority goals. Through information gathered from the assessment process at the previous step, staff can work towards reaching consensus on the goal(s).

Shared goals and activities among staff increase their interest and commitment and the effectiveness of improvements[32]. The entire improvement process, including goal-setting should take place with involvement from all staff.

Developing an Action Plan: Once the goal is selected, an action plan is developed to reach the goal. Action plans include:

- Necessary activities
- Resources needed, (e.g. materials, staff training, schedule adjustments)
- Person or persons responsible for carrying out the activities
- Targeted timelines for completion of the activities

Documenting and distributing this plan of action to all staff will maximize enthusiasm and participation in this effort.

Implementing and Monitoring Plan of Action:Identifying one person to coordinate and manage the implementation of the plan of action increases the effectiveness of the process. In addition to monitoring completion of activities specified in the plan, it is important to monitor student performance based on implementation of the activities. Adjustments to the original plan may be necessary.

Evaluating for Effectiveness: Once the plan of action has been carried out, evaluation of progress towards meeting the goal is completed. A decision is made either to continue with the original goal by identifying new activities or to begin working on a new goal.

Regular and ongoing evaluation of student behavior management policies and procedures insures that they are kept current rather than becoming out- dated, inconsistently followed and thus ineffective. **Regular and ongoing evaluation of effective school processes to improve student behavior is a common characteristic among responsible school systems.**

Step 4: Special Education-Based Interventions and Service Options:

1. Mainstream classroom
2. Part-time mainstream/resource placement
3. Behavioral counseling approach for SED students
4. An individualized behavior management program for each student
5. Behavioral consultation
6. Alternative educational programs
7. Continuation of all resources and interventions from previous steps
8. Parent/family training

Step 5: Community-Based Interventions and Service Options:

1. Coordination and collaboration between school and community resources
2. A procedure for reintegrating students into the regular school program
3. Continuation of all resources and interventions from previous steps
4. Self-contained classroom
5. Special day treatment school
6. Residential placement

Appendix G
Project Wrap

Partners Project information provided by the project.

MATERIAL NOT COPYRIGHTED

Oregon

DEPARTMENT OF
HUMAN
RESOURCES

MENTAL HEALTH
AND
DEVELOPMENTAL
DISABILITY SERVICES
DIVISION

OREGON'S MULTNOMAH CO. PARTNERS' PROJECT

WHAT IS THE PARTNERS' PROJECT?

A project that is supported, in part, by funding from the Robert Wood Johnson Foundation, awarded to the Oregon Office of Child and Adolescent Mental Health Services within the Oregon State Mental Health and Developmental Disability Services Division to develop a coordinated, family-centered, community-based system of care for children/adolescents that are severely emotionally disturbed.

WHERE IS THE PARTNERS' PROJECT?

The project is operated by the Multnomah County Department of Social Services through Multnomah County Mental Health, Youth and Family Services Division. The Oregon State Office of Child and Adolescent Mental Health Services oversees the development and implementation of the Project.

WHO IS SERVED IN THE PARTNERS' PROJECT?

Families and their children/adolescents whose emotional impairment puts them at imminent risk of inpatient psychiatric hospitalization or long-term residential care.

Eligible children/adolescents must meet the following criteria:

a. an emotional impairment in two or more major areas: self-care; interpersonal relationships; self-direction; in jeopardy of being separated from family and/or ability to learn
b. a DSM III-R diagnosis
c. the impairment has existed for more than 6 months
d. the child is between the ages of 5 and 18
e. the child is at risk of separation from the family
f. the child is a resident of Multnomah County and resides within Portland Public Schools and Centennial School District
g. the child is within the jurisdiction of 2 or more Partner agencies
h. there is some expectation of benefit from treatment

The maximum number of children eligible for the project at this time are 150 children during any month.

12/92

Barbara Roberts
Governor

2575 Bittern Street NE
Salem, OR 97310-0520
Hearing Impaired
(503) 373-1449
FAX (503) 373-7951

AN EQUAL OPPORTUNITY EMPLOYER

WHAT SERVICES ARE PROVIDED?

The Partners' Project utilizes a Managed Care Model of service delivery and authorization in which each child/family is assigned a Project Managed Care Coordinator. Care Coordinators work with the families and agencies involved with the child to develop an individualized family service plan. The Coordinator, along with the child's family and other involved professionals, comprise a service planning and delivery team. This team designs a service package to meet the specific needs of the child and family; the Care Coordinator has the responsibility for authorizing payment and assessing the progress and continuing appropriateness of each service.

Services may include, but are not limited to; evaluation, crisis treatment sevices, day treatment, respite care, intensive family-based treatment services, therapeutic foster care, psychopharmocology, outpatient treatment, after school daily structure and support, transportation, individualized mental health services through agencies serving the child and community support services.

WHO PAYS FOR SERVICES?

What is unique about the project is the evolving partnerships across state and local agencies: State and Regional Children's Services Division, State Mental Health and Developmental Disability Services Division, School Districts (presently Portland Public Schools and Centennial School District), State Office of Medical Assistance, and Multnomah County Department of Social Services. These Partners support a flexible pool of funds to pay for and design individual services to meet the needs of individual families and their children.

WHAT ARE THE PARTNERS' PROJECT CORE VALUES?

See attached sheet.

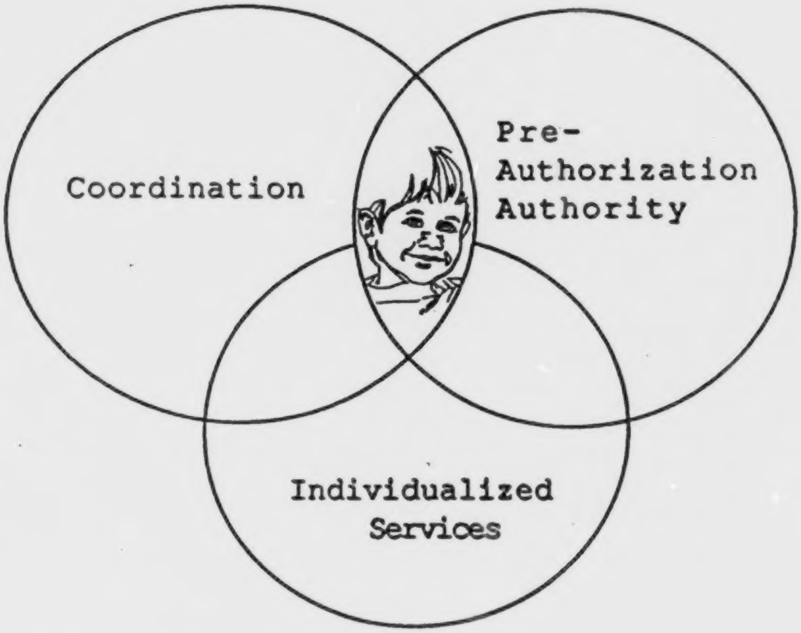
WHOM DO YOU CONTACT FOR INFORMATION?

Ralph Summers, Robert Wood Johnson Coordinator, State Mental Health and Developmental Disability Services Division, Office of Mental Health Services, Child and Adolescent Services Section
2575 Bittern Street N.E., Salem, Oregon 97310
Phone: (503) 378-8406

Elleen Deck, Project Manager, Multnomah County Mental Health, Youth and Family Services Division, 426 S.W. Stark Street, 7th Floor
Portland, OR 97232
Phone: (503) 248-3999

OREGON'S MULTNOMAH COUNTY
Partners' Project Model

Managed Care


Coordination
Pre-Authorization Authority
Individualized Services

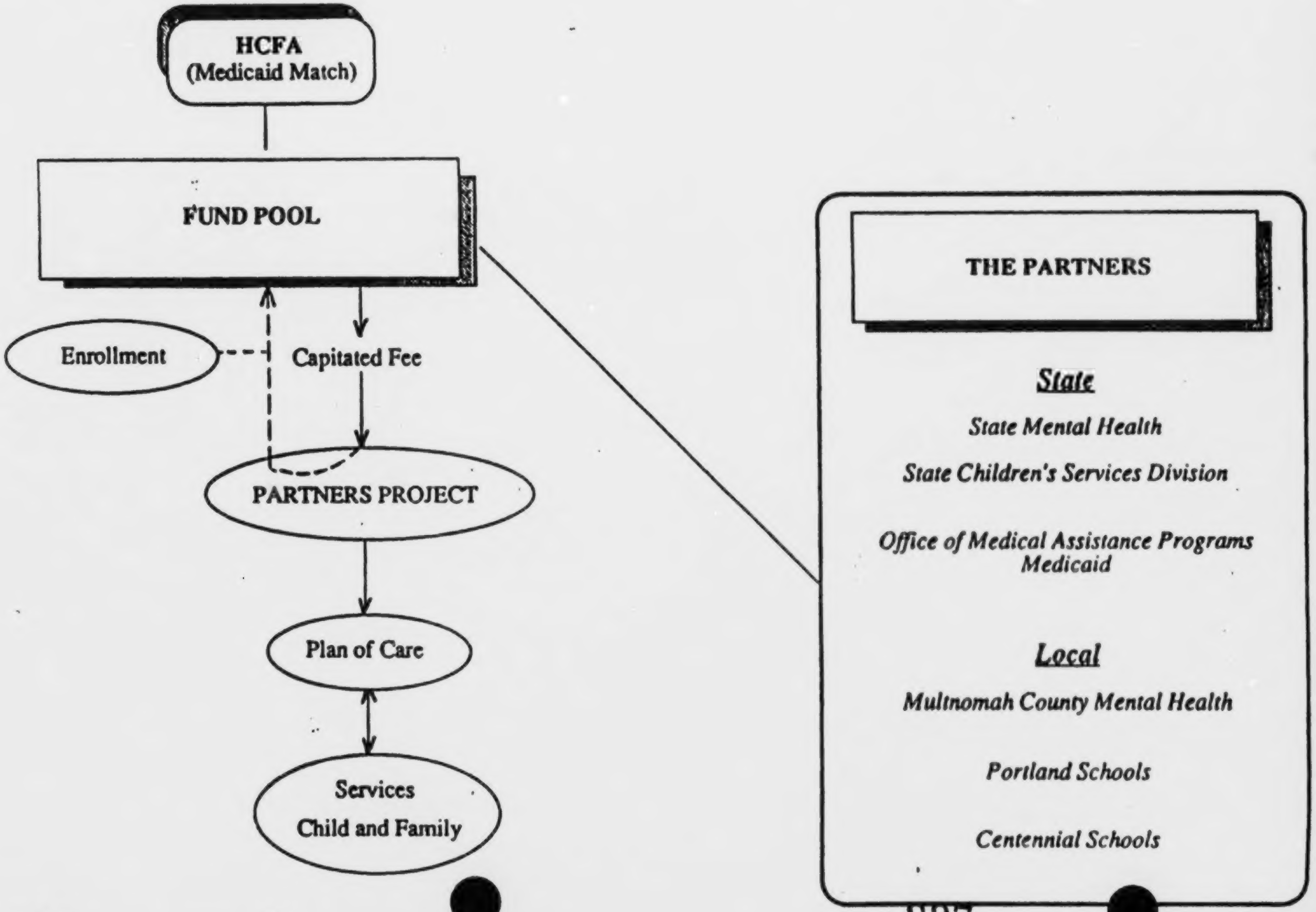
Coordination: Development of a plan of care which includes family and interagency collaboration.

Individualized Services: Services developed to meet needs of child/adolescent/family NOT simply based on available services.

Pre-authorization Authority: Efficient and/or timely approval and provision of services.

"MULTNOMAH COUNTY PARTNERS' PROJECT"

NEW MECHANISMS FOR SINGLE STREAM FUNDING: OREGON



HCFA
(Medicaid Match)

FUND POOL

Enrollment

Capitated Fee

PARTNERS PROJECT

Plan of Care

Services
Child and Family

THE PARTNERS

State

State Mental Health

State Children's Services Division

Office of Medical Assistance Programs
Medicaid

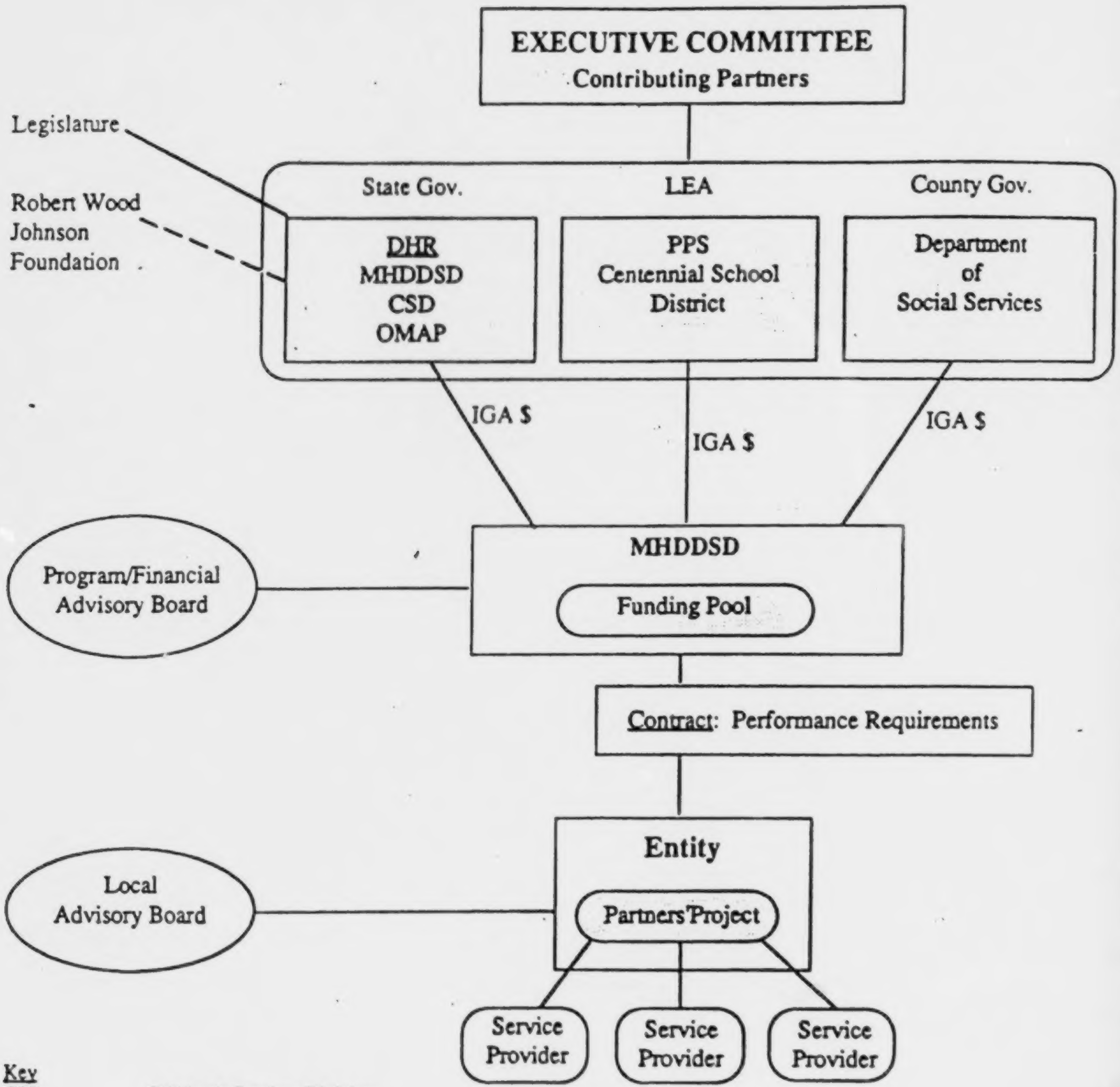
Local

Multnomah County Mental Health

Portland Schools

Centennial Schools

PARTNERS' PROJECT GOVERNANCE MODEL


EXECUTIVE COMMITTEE
Contributing Partners
Legislature
Robert Wood Johnson Foundation
State Gov.
LEA
County Gov.
DHR
MHDDSD
CSD
OMAP
PPS
Centennial School District
Department of Social Services
IGA $
IGA $
IGA $
Program/Financial Advisory Board
MHDDSD
Funding Pool
Contract: Performance Requirements
Entity
Local Advisory Board
Partners Project
Service Provider
Service Provider
Service Provider

Key

CSD	Children's Services Division
DHR	Department of Human Resources
IGA	Intergovernmental/Agency Agreement
LEA	Local Education Agencies
MHDDSD	Mental Health & Developmental Disability Services Division
OMAP	Office of Medical Assistance Programs
PPS	Portland Public Schools

9/1/92

Governance Structure for the Partners' Project

September, 1992

The Partners' Project Governance Model has evolved during Project implementation in the last two years. Through Project interagency collaboration the Partner agencies have clarified and "fine tuned" the original governance model in order to have a functional process for Project oversight and decision-making. The revised Partners' Project Governance Model describes the administrative/committee structures, responsibilities of each committee and staff assigned to each committee. The Project Entity's role and performance requirements are briefly described with more specific performance and reporting requirements to be outlined in the contract with the Entity administration. A draft of proposed performance and reporting requirements are attached.

The governance model describes three primary committees that advise the Project. The Executive Committee is made-up of Partner agency administrators and provides executive leadership for the Project. The Program/Finance Advisory Board is made-up of Partner agency representatives, a parent organization designee, and an industry representative whose role is to advise and provide technical assistance to the State Mental Health and Developmental Disabilities Services Division in Project administrative support and grant management. The third committee is the Local Advisory Board made-up of local Partner representatives, other agencies involved in children's plans of care, families, consumers, and providers who advise the Entity regarding Project implementation, management, and performance issues.

EXECUTIVE COMMITTEE: Role is to represent funding authority of respective Partner agency and to give executive direction

Responsibilities include:	Staff to Committee:
• Decision on the amount of agency contributions • Assist in reduction of systems barriers	State Project Coord.

Participation: Agency administrators

MENTAL HEALTH AND DEVELOPMENTAL DISABILITY SERVICES DIVISION: Role is to provide state administrative support to Project

Responsibilities include:

- Grant administration: programmatic, financial
- Contract authority
- Maintain funding pool
- Develop & process Interagency/Intergovernmental Agreements
- Selection of the Entity
- Manage federal funding issues: Health Care Financing Administration; revising Medicaid State Plan as needed

Staff:

- Manager of the Office of Child and Adolescent Mental Health Services
- State Project Coord.
- State Financial Coord.

PROGRAM/FINANCE ADVISORY BOARD: Role is to advise and provide technical assistance to the Mental Health and Developmental Disability Services Division in carrying out Project administrative support and RWJF grant management

Responsibilities include:

- Facilitate Partners collaboration and coordination:
  - assist in reduction of systems change barriers
- Development of policies including:
  - interagency collaboration/coordination
  - number of children to be served
  - percent of XIX children
  - approve of local program policies i.e. transferred children issues
- Advise in the selection of entity
- Advise on federal funding issues

Staff to Board:

- State Project Coord.

Participation: Agency designees: parent organization designee; industry representative

ENTITY: Role is to perform as contractor to provide managed care to Partners' Project children and implement model as designed and in accordance with the contract.

PERFORMANCE REQUIREMENTS: (see attached proposed detailed performance requirements)

- Total children enrolled not to exceed 150 each month (next six months)
- 67% children served are Title XIX eligible
- Services provided in accordance with OAR 309-16-000 et seq., Medicaid Payment for Community Mental Health Services
- Carry-out goals and objectives of RWJF grant

- Carry-out performance and reporting requirements specified in contract

REPORTING REQUIREMENTS: (see attached proposed detailed reporting requirements)

LOCAL ADVISORY BOARD: Role is to advise the Entity in Project implementation and ongoing performance issues

Responsibilities include:	Staff to Board:
• Advise on programmatic issues such as; services, managed care	Entity staff
• Assist in local coordination/collaboration (networking)	
• Advise in systems change at the local level	
• Develop programmatic policies	
• Advise in referral/eligibility process	
• Advise in collaborative training	
• Participate in Project hiring	
• Advise in problem solving i.e. for child/family; service development	
• Solve systems barriers	

Participation: Local Partner representatives, other agencies involved in plans of care, families, consumers, providers

9/4/92

PARTNERS PROJECT CORE VALUES

CORE VALUES FOR THE PARTNERS PROJECT SYSTEM OF CARE

1. The system of care should be child-centered and family focused, with the needs of the child and family determining the types and mix of services provided.

   Operationalizing goal: The Partners Project will work to develop a system of care that is flexible, accessible, and responsive to the needs of children and their families. This includes involving consumers in individual service plans, program development and policy formation.

2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

   Operationalizing goal: The Partners Project will build a system of care insuring that all aspects of service planning take place in the child's and family's home community. Though services are developed in this community, the project will solicit the support of state, federal and other resources in this endeavor.

GUIDING PRINCIPLES OF THE PARTNERS PROJECT SYSTEM OF CARE

1. Children who are identified as emotionally disturbed should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs in a timely fashion.

   Operationalizing goal: **The Partners Project will develop a child centered and family focused individualized plan for obtaining access to this array of services for the child and family when circumstances interfere with the parents' ability to meet their own needs and those of their dependent children.**

2. **Children who are identified as emotionally disturbed should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.**

   Operationalizing goal: **The Partners Project will insure that a service plan individualized to meet the needs of the child will be developed for each child. The plan will recognize family strengths and individuality and respect for different methods of coping.**

3. Children who are identified as emotionally disturbed should receive services in a timely manner within the least restrictive, most normative environment that is clinically appropriate.

Operationalizing goal: Maintenance in the family setting and family preservation as well as full community integration into social, educational, and recreational activities will be supported by the project. The Partners Project will plan for the provision of services in the most natural, dignified, and home-like environment in a manner that integrates children with emotional disturbances into community life.

4. The families and surrogate families of children who are identified as emotionally disturbed should be full participants in all aspects of the planning and delivery of services.

Operationalizing goal: The Partners Project will solicit involvement of parents and other family members in the planning and policy formation of the project.

5. Children who are identified as emotionally disturbed should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.

Operationalizing goal: The Partners Project will work with other public agencies, service providers, and consumers to plan for and develop a system of care that is integrated, comprehensive, and offers services sensitive to the unique needs of communities and their subcultures.

6. Children who are identified as emotionally disturbed should be provided case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that children and families can move through the system of services in accordance with their changing needs.

Operationalizing goal: The Partners Project will convene family members, agencies, and service providers on a regular basis to ensure that service plans are coordinated and responsive to the needs to the child and family.

7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

Operationalizing goal: The Partners Project will support efforts of early identification and intervention and will expand the Partners Project into this area as soon as this is feasible given the current funding realities. The project will work with others to identify funding to help the project move in this direction.

8. Children who are identified as emotionally disturbed and in need of continuing services should be ensured smooth transitions to the adult service system as they reach maturity.

Operationalizing goal: In order to insure uninterupted services to children and families, the Partners Project will plan with parents, children, and providers of services to both children and adults to (1) identify services needed from the adult service system, (2) link the child and family to those services, and (3) document unmet service needs for further planning and advocacy efforts.

9. The rights of children who are identified as emotionally disturbed should be protected, and effective advocacy efforts for emotionally disturbed children and youth be promoted.

Operationalizing goal: The Partners Project will protect the rights of children served by the project in accordance with the law. This includes setting up appeals systems, disclosure of information, and any due process rights accorded by law. The Partners Project will also cooperate with, support, and participate in system advocacy efforts occurring on behalf of children with emotional disturbances.

10. Children who are identified as emotionally disturbed should receive services that are sensitive and responsive to cultural differences and special need without regard to race, religion, national origin, sex, physical disability or other characteristics.

Operationalizing goal: In addition to complying with all laws and state administrative rules regarding accessibility and discrimination, the Partners Project will train its staff in disability awareness and cultural competence and sensitivity as well as promote these qualities in the services it develops.

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Lippincott, R. C., & Summers, R. (1994, Spring). Partners Project influences Oregon's statewide health care reform. *Family Matters*, pp. 10 - 12, 17.

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Partners Project Influences Oregon's Statewide Health Care Reform

by Richard C. Lippincott, M.D., and Ralph Summers, M.S.W.

The Multnomah County Partners Project in Portland, Ore., is a collaborative effort designed to provide coordinated, individualized, community-based services for children with severe mental, emotional, and behavioral disorders who are being served by two or more of these systems: special education, child welfare, juvenile justice, and mental health. The Partners Project is considered a success from various points of view—both clinically and economically, and as a model for organizing services to children with serious emotional illness in Oregon's health care reform environment under the Oregon Health Plan.

Much of what has been learned from the Partners Project can be applied to health care reform. Individualized services, family involvement in service planning, delivery, and evaluation, and flexible funds are critical methods for improving the outcome of services for children, adolescents, and their families. A rich and comprehensive array of services with strong linkages between youth serving systems and rapid access to any package of services that best meets the needs of a child or family are the foundation for a "system of care." Managing services across multiple agencies improves the outcome of services for children and families and increases overall system efficiency, eliminates duplication, and reduces cost shifting.

The Oregon Health Plan (OHP) is a legislatively approved plan for universal access to health care using a combination of public and private insurance plans. The plan, which started February 1, 1994, is being phased in over several years. Currently the OHP provides physical medicine to people on Medicaid by virtue of their eligibility for the Aid to Families with Dependent Children program and households at or below 100 percent of the federal poverty level. The OHP includes a Medicaid demonstration, a state-administered high-risk insurance pool, and mandated employer paid insurance.

Principles of the OHP that are of interest to those concerned with health care reform are universal coverage, the development of fully capitated prepaid health plans, the integration of mental health and chemical dependency disorders into the benefit package, and the concept of a standard benefit package based on a prioritized list of disorders and their appropriate treatments.

The success of the Partners Project has offered Oregon a preview opportunity to explore issues involved in the inclusion of mental health coverage in equal status with all health care as part of reform. The goal for children with severe mental, emotional, and behavioral disorders is to assure that they and their families have access to the same mainstream health care as every other citizen, including a comprehensive array of mental health services. The challenge before us is to incorporate the system of care lessons learned from the Partners Project into Oregon's larger health care reform effort.

Richard C. Lippincott, M.D.

Ralph Summers, M.S.W.

The Partners Project predated any service model development for the mental health portion of the Oregon Health Plan. The planning phase for the Partners Project began in the spring of 1989 and the first children were enrolled

236

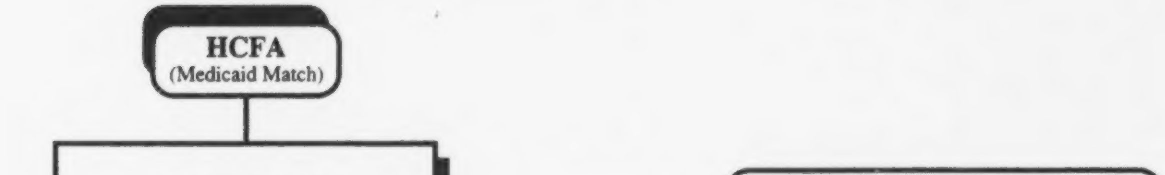
in the fall of 1990. The Partners Project, based on interagency service integration and pooling of resources under the control of a single case manager, eventually involved seven partners including the Robert Wood Johnson Foundation (see chart). The Multnomah County Office of Child and Adolescent Mental Health Services was established as the project "entity" responsible for covering mental health services for enrolled children through a global prepaid, all-inclusive monthly rate. The rate covered a wide range of community-based mental health related services for multiagency-involved children with severe mental, emotional, and behavioral disorders but excluded residential care and hospitalization. The rate included the costs of managed care coordinators and local project management as well as direct services costs. The entity paid service providers and insured that the unique needs of each child were met.

We believe that the outcomes and values of the Partners Project fall into four main categories.

First, the project focused on the individual clinical needs of the child and family. It brought together as a "service team" all the players within a child's life, including family, schools, juvenile justice, child welfare, and mental health, and provided a managed care coordinator to authorize payment for services based on

(continued on page 12)

Multnomah County Partners Project
New Mechanisms for Single Stream Funding


HCFA
(Medicaid Match)
FUND POOL
Enrollment
Capitated Fee
PARTNERS PROJECT
Plan of Care
Services
Child and Family
THE PARTNERS
State
State Mental Health
State Children's Services Division
Office of Medical Assistance Programs
Medicaid
Local
Multnomah County Mental Health
Portland Schools
Centennial Schools

Partners Project

(continued from page 11)

accountability, progress, and coordination. It is important for both child and family to understand the options for treatment and to be fully involved in establishing treatment goals. Flexibility in the use of the capitation funds is emphasized.

Second, the project set standards and invested in documenting the following outcomes: effectiveness in interagency linkages; access to services; monitoring service effectiveness; and using the data developed to provide feedback to the service teams and to the project as a whole.

Third, the project changed the service delivery settings and systems. Use of hospitalization is down. Services provided in the community and home are up. A shift toward the use of family interventions that allow a child to remain at home, an emphasis on improving skills and competencies, and providing individualized mental health aides within the classroom rather than removing the child to a more restrictive setting are examples of the flexibility of services and the changes that have been implemented.

Last, the Partners Project has demonstrated both clinical and cost effectiveness. Data document the fact that children' symptoms are stabilizing as a result of services provided. Cost savings that resulted from changing service utilization patterns are being used to enhance the array of service options.

The Partners Project's experience of building a managed system of care using Child and Adolescent Service System Program (CASSP) values and its family support philosophy will have a profound impact on Oregon's health care reform decisions. Important values of the Partners Project, such as individualization of services, family involvement, inclusion of a wide range and intensity of services in the benefit package, collaboration with other agencies, and use of flexible funds, are being applied as decisions are being made about Oregon's health care reform.

Much of the Partners Project model has been used statewide to manage Oregon's fee-for-service Medicaid system for children and adolescents with severe mental, emotional, and behavioral disorders, particularly those served by multiple agencies. Recently the state and Multnomah County have begun to explore the creation of a managed care organization for all mental health services provided to Medicaid-eligible children, ages birth to 21, based on the Partners Project experience.

The integration of mental health services into the Oregon Health Plan has been supported and strengthened by the Partners Project experience. When state policy makers worked with the actuaries to establish the rates, all of the services in the system of care were examined. This included community-based rehabilitative services, psychiatric day treatment, treatment foster care, residential psychiatric treatment, local acute psychiatric hospitalization, and state psychiatric hospitalization. While these services may not all be delivered initially through prepaid health plans, they are included in the state's view of a comprehensive mental health benefit package for children that is integrated with medical care. The longer term goal is the full integration of mental health and health care. This will provide children with severe mental, emotional, and behavioral disorders and their families an entitlement to a full array of mental health services on an equal basis with children who have serious chronic health problems.

Standards are currently being drafted for the delivery of mental health services under the Oregon Health Plan. CASSP values and principles will be written into the standards. Services will be determined by a comprehensive assessment. Prepaid health plans will be required to involve family members and form linkages with schools, child welfare, juvenile justice, and social service agencies to increase the coordination of services and avoid cost shifting. Data will be collected on client outcomes and the performance of prepaid health plans in order to assess the effectiveness of the system reform.

Health care reform brings a great deal of potential for children's mental health system improvements to federal, state, and local governments. For this potential to be realized we must keep in mind key lessons learned

(continued on page 17)

upper hand in the treatment of children whose angry and defiant behaviors disturb us, and transform their disturbing behavior into a label of "emotional disturbance." Once a child is labeled, it becomes easier to curtail a family's power to influence what happens to their children or to remand the "disturbed" child to a restrictive placement without the due process that would be afforded one criminally accused.

In our compassion, we all seek to secure the resources that are needed for families facing formidable challenges, but compassion is not well served by strategies that breed dependence or deny liberty.

If we are to avoid allowing the norms of acute health care, or for that matter any single treatment or support paradigm, to dominate our efforts on behalf of kids, then we must constantly labor to assure that our locally organized systems are structured and maintained as interagency systems. All of the important providers of services, and most especially families, must be involved in the development of systems, the delivery of services, and the process of constantly improving systems. The expertise of social services, special education, juvenile justice, and mental health agencies must all be present, and respected, if a comprehensive system of children's and family services is to succeed.

And all of the disciplines involved should be expected to contribute to funding. The availability of Medical Assistance funds, mental health insurance benefit mandates, or even a rich mental health benefit in a national health care plan cannot supplant other federal categorical programs for this population. A medical benefit cannot be expected to provide all of the social, educational, correctional, or economic services required to maintain children in a community setting. The categorical funding programs not only need to be maintained, but they need to allow more flexible use of funds so that dollars earmarked for institutional treatment and out-of-home placement can be used for community-based and in-home alternative services.

National health reform may provide a great opportunity to improve and expand services for emotionally disturbed kids, but let us be cautious and not expect too much from any single system.

***Michael Dunham** has been chief executive officer of health maintenance organizations in Wisconsin and New York. He is currently president of Community Care Management Inc., the agency that operates the MHSPY-supported Children Come First program in Dane County, Wisconsin.*

Partners Project

(continued from page 12)

from the Partners Project. We must retain the "system of care" concept, encourage family involvement and interagency collaboration, create incentives for innovative and flexible use of service dollars, and provide reasonable oversight and system management.

***Richard C. Lippincott**, M.D., is the supervising psychiatrist for the Office of Mental Health Services, Oregon Department of Human Resources, Mental Health and Developmental Disability Services Division (MHDDSD), where he is responsible for the development of policies and systems to strengthen medical care for patients who receive public mental health care. He has headed MHDDSD initiatives to move more responsibility for care, with accompanying state dollars, from state institutions to local communities.*

***Ralph Summers**, M.S.W., is a program specialist in MHDDSD's Child & Adolescent Section and serves as state coordinator for the Partners Project, Oregon's MHSPY initiative. He currently is involved in the development of standards that will incorporate CASSP principles and system of care concepts into health care reform in Oregon.*

Appendix H
Southern Westchester IDT (Intensive Day Treatment) Program

Partnership for Family Preservation information provided by the project.

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Partnership for Family Preservation Children and Adolescents Network of DuPage County

PARTNERSHIP FOR FAMILY PRESERVATION
CHILDREN AND ADOLESCENTS NETWORK

PRINCIPLES OF CARE

The principles of care will guide all of the collaborative activities in the county. These principles will help individuals to work together to promote the child and family's interests and will help a child develop in a way that is responsive to the culture and community.

1. The system of care will be child or adolescent-centered, with the needs of the children and adolescents and their families dictating the types and mix of services provided.

2. The system of care will be community-based, with the location of services as well as management and decision-making responsibility residing at the local level.

3. Children and adolescents and their families will have access to a comprehensive array of services that address the child's physical, emotional, social, vocational, transitional, and educational needs.

4. Services for children and adolescents will be in accordance with the unique needs, strengths and potential of each child, as stated in the child's individualized service plan.

5. Transition planning (i.e., from setting to setting, from treatment to treatment, from adolescent services to adult services) will be an integral part of individual service plans.

6. Every effort will be made to involve families in the planning and delivery of services.

7. Agencies will collaborate to provide coordinated and integrated services for children and adolescents and their families with specific mechanisms for planning, developing and coordinating services.

8. Early identification and intervention for children and adolescents will be promoted by the system of care in order to enhance the likelihood of positive outcomes.

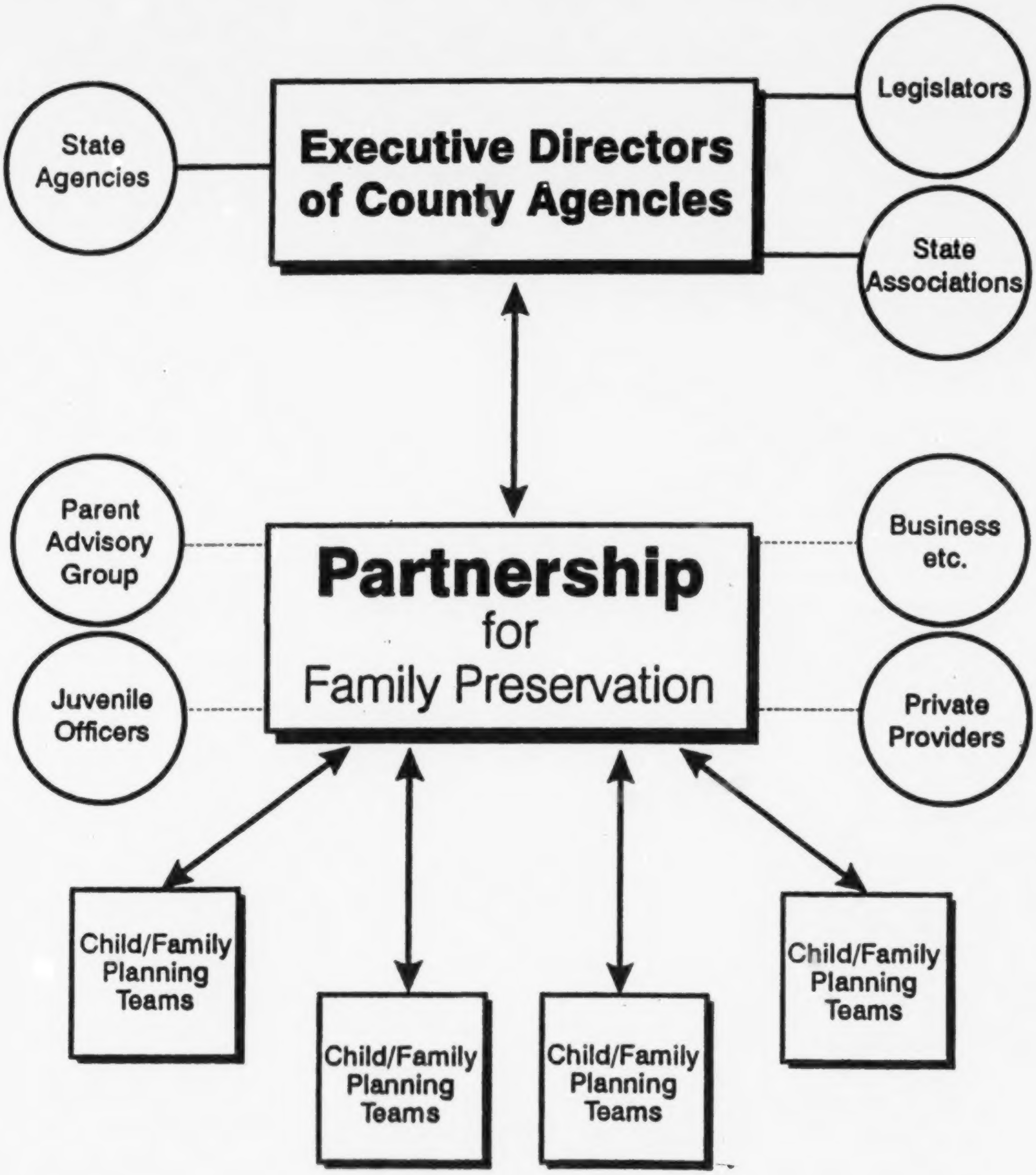
9. The rights of children and families will be protected and advocacy for children and adolescents and their families will be promoted.

10. Children and adolescents will receive services which are sensitive and responsive to cultural differences, without discriminating on the basis of race, religion, national origin, creed, sexual orientation, gender, disability or other characteristics.

11. Services will help children and families to become as self-reliant as possible.

12. When services are not meeting individual needs, new approaches and plans will be developed and implemented.

Community Network Model



State Agencies

Executive Directors of County Agencies

Legislators

State Associations

Parent Advisory Group

Juvenile Officers

Partnership
for
Family Preservation

Business etc.

Private Providers

Child/Family Planning Teams

Child/Family Planning Teams

Child/Family Planning Teams

Child/Family Planning Teams

COMPONENTS FOR BUILDING SERVICE PARTNERSHIPS FOR CHILDREN AND FAMILIES

MENTAL HEALTH COMPONENTS

- Public Information
- Early Identification/Intervention
- Assessment
- Financial Assistance
- Outpatient Treatment
- Long/Short-Term Planning
- Independent LivingServices
- Home-Based Services
- Day Treatment
- Continuum of Placements
- Residential Treatment
- Emergency Services
- In-Patient Hospitalization

CHILD WELFARE COMPONENTS

- Protective Services
- Prevention/Information
- Financial Assistance
- Medical Assistance
- In-Home Assistance
- Continuum of Placements
- Reunification
- Adoption

HEALTH COMPONENTS

- Prevention
- Early Intervention
- Health Education
- Assessment & Planning
- Financial Assistance
- Home-Based Services
- Medical Respite
- Day Care

JUVENILE COURT

- Protective Services
- Court Supervision
- Probation
- Continuum of Placements
- Parole Services

ALCOHOL & SUBSTANCE ABUSE COMPONENTS

- Prevention
- Early Intervention/Education
- Assessment/Planning
- Financial Assistance
- Continuum of Placements

RECREATIONAL COMPONENTS

- Special Recreational Projects
- After-School Programs
- Summer Camp

EDUCATIONAL COMPONENTS

- Regular Education
- Assessment /Planning
- Gifted Education
- Special Education
- Home/Hospital Instruction
- Continuum of Placements
- Vocational Education
- College Education

VOCATIONAL COMPONENTS

- Career Education
- Job Retention Services
- Job Training Skills
- Job Find/Placement
- Work Experience
- Independent Living-Skills Training
- Sheltered Employment

OPERATIONAL PRACTICES
(Common to All Service Components)

- Self-Help/Support Groups
- Transitional Planning
- Advocacy
- Dispute Resolution
- Volunteer Programs
- Due Process/ Administrative Review
- Training
- Transportation
- Case Management
- Legal Services

CHILD & FAMILY

Adapted by RSA from Beth A. Stroul, M.Ed. and Robert M. Friedman, Ph.D.
A System of Care for Severely Emotionally Disturbed Children and Youth 1986.

TRADITIONAL MODEL OF MENTAL HEALTH ASSESSMENT COMPARED TO STRENGTHS-ASSESSMENT

TRADITIONAL MODEL	STRENGTHS MODEL
Medical model, terminology	Focus on the child-in community, and the child as a bio-psycho-social being
Focuses on personal "history"	Refocuses on child-in-the-present
Highlights symptoms	Highlights capabilities
Focuses on "labels"	Focuses on action steps
Restricts interventions to identified "helpers" (agency staff)	Spotlights extra-agency supports, recognizes contribution of family, natural helpers, community resources
"Client" is passive	The child & family can be active participants
Assessment and goal planning is developed unilaterally	Conjointly determined
	Hopeful, open-ended

Developed by: Charles Rapp
Adapted by: Anita Kinsley, MA; 1993

Appendix I
Stark County System of Care

Project Wrap information provided by the project.

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Lucille Eber, Ed.D.
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Susan Birkenmaier
Business Manager

PROJECT WRAP: INTERAGENCY COLLABORATION THROUGH A SCHOOL-BASED WRAPAROUND APPROACH

Presented at the 6th Annual Research Conference
A System of Care for Children's Mental Health:
Expanding the Research Base

March 1 - 3, 1993

Tampa, Florida

Lucille Eber, Ed.D.,
Project WRAP Director

Carol Stieper,
Project WRAP Phase I Coordinator

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Table 1:

PROJECT WRAP
MODEL SYSTEM COMPONENTS

Model System Components Identified in the Literature*	Project WRAP Activities/Components	Phase I	Phase [illegible]
Needs Assessment and Planning	Systems Assessment	X	X
	Planning at Coordinating Council Level	X	X
	State Coalition		X
	Involve legislature		X
Constituency Building	Coordinating Council	X	X
	Wrap-Around Interagency Network	X	X
	Collaboration Around Target Cases	X	X
	State Coalition		X
	Illinois Federation of Families		X
Interagency Collaboration	Coordinating Council	X	X
	Wrap-Around Interagency Network	X	X
Local Systems Development	Respite	X	X
	Parent Partners	X	X
	Parent Network	X	X
	In-Home Options	X	[illegible]
	School Inclusion Model		X
Modify Mental Health and Special Education Systems	Redirection of Department of Mental Health Residential funds	X	X
	School Inclusion Model		X
	In-Home Services	X	X
	Respite	X	X
	Mental Health in Schools	X	X
	Peer Support Programs	X	X
Technical Assistance Training	WRAP Training Network	X	X
	Coordinating Council	X	X
	Wrap-Around Interagency Network	X	X
	State Coalition		X
	WRAP Parent Network	X	X
	Illinois Federation of Families	X	X

*(Boyd, 1992; Nelson & Pearson, 1991; Stroul & Friedman, 1986.)

Table 2: PROJECT WRAP

CRITICAL NEEDS WHICH EMERGED THROUGH THE PROJECT WRAP SYSTEMS ANALYSIS

Area of Need	Specific Description of Need
Family/Home	In-home respite and community-based alternatives to residential services;
	Out-of-home and emergency respite; community-based shelter for MIRA youth mandating in-home family preservation services
	In-home family support/counseling/family preservation services to the family prior to any placement of a child in residential care
Parent Supports/Services	Parent led support groups
	Advocacy services
	Parent training groups that provide babysitting
Community/Recreational	Inclusive recreation programs in the community
	Supervised after-school programs providing normalized social activities
	Community-based (vs. home-based) therapeutic respite services
	Summer programming for youth with EBD
Schools/Educational	Development of models and techniques for inclusion of students with EBD in regular classrooms in neighborhood schools
	Increased and more meaningful parent involvement with school teams
	Intensive case coordination services that are school-based
	Day treatment in normal school setting for youth with chronic mental illness
	A change in the type of communication schools initiate with the parent: problem-solving and progress update contacts
	Creating true partnerships between schools and parents
	Truancy intervention that is outcome directed
	School teams that collaborate/plan meetings jointly when working with children from the same family in different schools
	School scheduling meetings that take the parents work schedule into account
	Family supports for school staffings, using family friendly language in school meetings
	Assessment services by an interagency team that is activated by school referral for more restrictive placement
	Eliminate home-bound status for behavioral reasons

Area of Need	Specific Description of Need
Schools/Educational (continued)	Peer support programs.
	Making school staffings focus more on the child and less on the regulations and paperwork
	Reducing school suspension of students with EBD
	Brochure regarding parents rights and special education that are written in family-friendly language.
	Behavior management consultants that can be utilized by school staff and family for unified planning prior to reintegration in home or district school, following day or residential placement.
Case Management	Individualized case planning assistance that is family inclusive and is provided to school team, community service providers and the family.
	Case management services that work in partnership with the parent and focus on team development, development and coordination of services, accessing services and funding for services, monitoring and evaluating implementation of services, establishing normalized measurable outcomes.
	Increased interagency collaboration in case management.
	Someone to help parents in identifying and evaluating service needs, options and providers.
Psychological/Mental Health Services	In-home counseling services and supports.
	Babysitting during in-office treatment.
	Reduction in fragmented service delivery.
	Multi-system involvement in comprehensive assessment and diagnostic evaluation.
	Primary prevention programs in grade schools regarding drugs, gang, dropping out and pregnancy.
	Crisis intervention services.
	Community-based hotline services
	School-based services to student and to school teams.
	Community-based intervention and service models that are more comprehensive and normalized than in-office therapy sessions.
	Need to reduce duplication in services.
	Need for mental health provider to work in conjunction with other providers of service to the family such as physicians and the extended family network.
	Peer counseling programs for adolescents.
Medical	Accessible and affordable drug testing.
	Low cost health care.

Area of Need	Specific Description of Need
Training	Parents and school personnel: diagnostic labels and what this means in relation to needs and services.
	Parents: learning how to navigate the human service and special education systems and advocate for services for their child.
	Dealing with physical aggression in the school and home.
	How to develop and implement effective school inclusion plans that involve teachers, parents and mental health.
Funding Structures	Reallocation of funds to support a broad array of home and community-based supportive services.
	Insurance funding of partial programs psychiatric hospitals.
	Decategorization of funding/flexible dollars: needs-based not service-based planning.
	Individual Care Grant use for funding of in-home service as an alternative to residential placement.
	Funding for alternatives to in-patient care as well as for after insurance is depleted.
	Funding for community-based services rather than placing services in institutional settings outside the community.
	Insurance funding of respite services.
	Eliminating financial incentives for more restrictive services.
Resource Development: Information and Access	Wider access to information regarding public aid, medicaid, SSI and other funding streams for services regarding eligibility requirements and service information.
	Parent networking regarding evaluation of services (consumer-based evaluations).
	Services for identifying resources, "brokering" services and funding for services for families.

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SCHOOL INCLUSION AS A STRATEGY FOR LINKING WITH EDUCATION

RWJF Mental Health Services Program for Youth Annual Meeting
Hyatt Regency - Capitol Hill, Washington, D.C.

October 20-22, 1993

Lucille Eber, Ed.D.
Director, Project WRAP
La Grange Area Department of Special Education
1301 W. Cossitt Avenue
La Grange, IL 60525
708/354-5730

Serving the school districts of:

95 — Brookfield-La Grange Park
96 — Riverside
101 — Western Springs
102 — La Grange (North)
103 — Lyons
105 — La Grange (South)
106 — La Grange (Highlands)
107 — Pleasantdale
181 — Hinsdale
86 — Hinsdale Township High School
204 — Lyons Township High School
208 — Riverside-Brookfield High School

Ladse

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LADSE'S PROJECT WRAP:

INTERAGENCY SYSTEMS CHANGE THROUGH A SCHOOL-BASED MODEL

- **The WRAP Coordinating Council: Interagency systems planning**
- **The Wraparound Interagency Network (WIN): Case coordination**
- **Wraparound in Schools (WAIS): Inclusive school opportunities**
- **The WRAP Parent Network: Advocacy, support and resource development**
- **Buddy Program: Home, school, community support**
- **Parent Partners: Parent to parent service provision**
- **Peer Supports: Peer support networks in natural environments**

Serving the school districts of:

53 — Oak Brook
61 — Darien
62 — Gower
94 — Komarek
95 — Brookfield-La Grange Park
96 — Riverside
101 — Western Springs
102 — La Grange (North)
103 — Lyons
105 — La Grange (South)
106 — La Grange (Highlands)
107 — Pleasantdale
181 — Hinsdale
86 — Hinsdale Township High School
204 — Lyons Township High School
208 — Riverside-Brookfield High School

LADSE'S PROJECT WRAP

PHASE II

WRAPAROUND INTERAGENCY NETWORK (WIN)	WRAPAROUND IN SCHOOLS (WAIS)	EVALUATION AND TECHNICAL ASSISTANCE (Statewide)
• interagency case review	• school inclusion	• qualitative & quantitative measures
• redirection of interagency resources	• new roles for special education providers	• student/family outcomes
• time limited case coordination	• facilitate use of wraparound inside schools	• interagency system change indicators
• noncategorical supports: Buddies, Parent Partners, In-home services	• peer support networks, Buddies, Parent Partners	• consumer feedback (parent, teacher, child, service provider, interviews)
• WRAP Parent Network and IFF (FFCMH)	• Wraparound as a prevention strategy for students at-risk of EBD	• Statewide network of system change initiatives

A SCHOOL INCLUSION MODEL FOR STUDENTS WITH EBD

New Model	Reallocation of Existing Resources
A. School Inclusion Facilitator →	Special Education Teachers, Consultants, Supervisors
B. Family Service Coordinator →	Social Worker
C. In-School Respite →	Paraprofessionals, Intern, Parents
D. Mental Health Providers →	CMHC, Interns, Private Providers,
E. Intensive In-Home Supports →	Res.Funds/Insurance/Medicaid/EPSDT
F. Family Respite →	Res.Funds/Insurance/Medicaid/EPSDT
G. Peer Support Component →	Teachers, Social Workers, Counselors, Interns

LADSE

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SUMMARY OF PROJECT WRAP:

INTERAGENCY SYSTEMS CHANGE THROUGH A SCHOOL-BASED MODEL

La Grange Area Department of Special Education (LADSE)'s Wraparound Project (WRAP) is a school-based systems change initiative for children with emotional and behavioral disabilities (EBD) and their families. WRAP is focused on improving outcomes for these children and their families by converting the existing categorical special education and mental health services into a more integrated and flexible system. The focus is on wrapping networks of support and services around children with EBD and their families in natural home, school and community settings. The ultimate goal is to integrate wraparound strategies and more inclusive options into the existing service delivery system and retrain service providers to facilitate these innovative approaches which are proving more effective for children and families.

The experiences of this school-based initiative over the past three years indicate that the concept of wraparound is useful as systems change mechanism as well as a service delivery approach. In the LADSE community, the collective focus is now directed towards more innovative and inclusive options in natural home, school and community settings. Residential dollars are being used for in-home services and local mental health centers are converting resources into support and coordination of respite services. Insurance companies are being enticed to fund intensive in-home treatment plans. School-based inclusion models have been initiated where special education teachers function as wraparound facilitators. School social workers broker resources for families instead of conducting the usual, but typically ineffective group counseling sessions for students in special classes.

Challenged with the need to redesign a more comprehensive system that results in better outcomes, this special education agency focused on a family-driven approach and a commitment to natural environments. The effects on local and state agencies is evident as reallocated resources are becoming more available to keep children in their homes and schools. The Illinois State Board of Education (ISBE) has enlisted LADSE's support in providing technical assistance and evaluation support for ten similar systems change initiatives throughout the state. Project WRAP demonstrates how special initiatives can become the impetus for systems change instead of just another short-lived special program.

Key components of WRAP which make it distinctive as a school-based initiative include:

- Focus on systems change by creating multiagency networks and focusing on changes in funding structures and policies across public and private agencies at the state and local levels.
- Development of a school inclusion model that applies the concept of wraparound inside schools for children with EBD as well as those at-risk of developing EBD.
- Facilitating the redistribution of special education resources to provide supports for children with EBD in a variety of school settings including regular education classrooms.
- Strong emphasis on family-driven plans and family leadership in interagency networks.
- Facilitating the development of a local family network which involves parents as paid service providers as well as development of the Illinois Federation of Families (IFF), an affiliate of the National Federation of Families for Children's Mental Health (FFCMH).
- Emphasis on developing and utilizing peer networks and Buddy program in schools and communities to facilitate effective inclusion of children with EBD.
- Extracting commitments from schools and other service providers to view children/families from a strength based perspective instead of from a pathology focus.
- Not placing children/families into existing categorical slots but creatively designing an individualized support network that addresses the actual needs of each child/family.
- Initiating the development of respite services, other in-home supports and inclusive recreational opportunities by building on strengths in the existing system and supporting community providers through a system conversion.
- Development of a multifaceted evaluation process focused on student/family outcomes, teacher/service provider perceptions, consumer feedback and systems change indicators.

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Appendix J
Ventura County Mental Health Children and Adolescent Project

Appendix J
Ventura County
Mental Health
C.A.P.

Southern Westchester IDT Program information provided by the project.

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ORANGE INTENSIVE DAY TREATMENT PROGRAM

OPERATED BY
ROCKLAND CHILDREN'S PSYCHIATRIC CENTER
ORANGE COUNTY SCHOOL DISTRICTS, &
ORANGE/ULSTER BOCES

IN COOPERATION WITH
ORANGE COUNTY DEPARTMENT OF MENTAL HEALTH

PURPOSE/NEED

Orange County lacks treatment alternatives to hospitalizing children and adolescents in crisis and to placing children and adolescents in residential programs. The County also lacks transitional services for the successful return of children and adolescents to their home communities following hospitalization or placement. Young persons in Orange County are hospitalized at a high rate for severe emotional crisis. In 1992 there were 261 inpatient admissions of children and adolescents at Arden Hill Hospital, Cornwall Hospital, Craig House, Stoney Lodge and Rockland Children's Psychiatric Center. Additional adolescents were also hospitalized at New York Hospital and Four Winds Hospital. The high number of inpatient admissions does not include the many children and adolescents in residential placement.

The proposed Orange Intensive Day Treatment (IDT) is an alternative to hospitalization and placement for many young persons in acute crisis. The program primarily serves children and adolescents in regular education. IDT supports the adolescent in crisis at home and in school, by expeditiously achieving short-term, symptom-reducing, behavioral goals. Crisis behaviors are returned to pre-crisis conditions through individual, family, and school interventions. IDT provides evaluation, treatment, and educational services that are aggressive, pragmatic and eclectic. Medication and family intervention techniques are utilized to stabilize the child. Parents are supported in maintaining responsibility for their child's behavior. Parents participate fully in treatment and crisis intervention. Adolescents are discharged from IDT in a timely manner through expeditious advocacy, discharge planning, and aftercare services. IDT provides the family and the school with comprehensive aftercare service planning. Aftercare services may include clinic treatment through the Department of Mental Health.

IDT enhances the opportunities for a successful return to the community and may also reduce the length of hospitalization through short-term, transitional services for adolescents discharged from psychiatric inpatient settings. Transitional services provide social, educational, and family adjustment in a supportive environment with comprehensive clinical services.

TARGET POPULATION

The population to be served is those young persons, ages 6-18 years, eligible for regular or special education placement within the Orange/Ulster Supervisory School District, who are in an acute phase of an emotional disorder. IDT will commence operations with one adolescent group of ten ages 13 to 18. IDT also serves discharged inpatients whose symptom stabilization requires a brief, supportive, treatment/educational setting in the community. IDT accepts referrals for crisis stabilization from the local crisis service, emergency rooms and from local schools. IDT accepts referrals for transitional services from hospitals returning an Orange County child/adolescent to his or her home school.

ADMISSION CRITERIA

The IDT clinical team, the home-school, the family, and the child/adolescent must approve participation in IDT. A psychiatric assessment is provided at intake and must indicate evidence of a psychiatric disorder, using the nomenclature of DSM IIIR. The child/adolescent's problems must be acute and require stabilization, where specific home, school, and community problems can be identified and addressed within four weeks of intensive services.

Children and adolescents with long term functional problems are appropriate for IDT only when their behavior is acute and can be stabilized to pre-crisis levels. However, persistent disorders lacking acute symptomotology are not considered appropriate for admission to IDT. Children and adolescents with a sole diagnosis of mental retardation or substance abuse are not appropriate for admission to IDT. Admission to the program requires the approval and the participation of the adolescent, the parent and the home-school. The clinical team shall provide recommendations for those children not admitted to IDT.

TRANSITION AND DISCHARGE

IDT expedites the child/adolescent's return to the home-school. Generally, discharge from IDT occurs within 30 days for adolescents and is somewhat longer for children. The discharge progress begins soon after admission with transition. The child/adolescent in transition returns to the home-school with a planned, carefully monitored, partial schedule of activities. During transition, the young person continues to attend IDT for treatment and support by the treatment team.

PROGRAM SIZE/LOCATION

IDT will commence with one adolescent group, 13 to 18 years of age. The group of 10 adolescents will meet daily. Since program capacity is 14 adolescents, 4 adolescents may receive brief day treatment services as follow-up. The program will be centrally located in Orange County, to meet county-wide transportation needs. Education is provided during the school day through the local school district. Transportation is provided by the local school district.

STAFFING & BUDGET

RCPC Personnel

Clinical Director/Psychiatrist	3/5 time
Social Worker	full time
Social Worker	3/5 time
Secretary	1/5 time

RCPC Non-personnel

Transportation
Supplies/Equipment/telephone

School Personnel

Special Education. Teacher	full time
Teachers Aide.	full time

School non-personnel
Supplies, Rental, utilities, custodians

THE IDT TEAM

The mental health members of the team are responsible for evaluations and treatment planning. The treatment plan is designed to stabilize the adolescent's behavior. They work to eliminate crisis producing behavior and increase the skills needed in the home-school setting.

The IDT teacher is responsible for the adolescent's educational plan. The teacher implements the educational programs from the home-school. Mental health and education team members give the adolescent, the parents, and the home-school the message: "We want you to make important changes in a short time, so you can return to your school. While you attend school here, a place will be kept for you at your home-school."

School liaisons to IDT are an essential educational component of the team. Liaisons are designated from each school district. In general, liaisons tend to be pupil personnel staff and will provide one hour per week for each of their students in IDT.

IDT AND THE HOME-SCHOOL

The receptivity and flexibility of the home-school administrators and teachers to the adolescent's return is crucial to the success of the discharge plan. Therefore, IDT staff place a high priority in maintaining contact with the home-school. The home-school liaison coordinates academic work and facilitates transition. The IDT teacher reviews completed assignments, but the home-school teachers grade the work. Many home-school teachers remain concerned and involved with their student and are accepting of the adolescent's return. Other home-school teachers require advocacy and support services to keep them committed to the adolescent's return. In some instances IDT may recommend a modification in the adolescent's school schedule, to reduce emotional stress and maintain symptom reduction.

INTERAGENCY PLANNING GROUP

The IDT planning workgroup consists of representatives from Orange County Department of Mental Health, Orange/Ulster BOCES, Rockland Children's Psychiatric Center, and local School Districts. The Orange County Mental Health Commissioner, the BOCES Superintendent and Assistant Superintendent , and the local Superintendents of Schools are active in the local development of IDT. The planning group will continue to meet to discuss, evaluate, and recommend modifications in IDT. IDT will monitor: the number of adolescents referred, the number of adolescents admitted, patient characteristics, diversions from hospitalization and residential placement, enrollment, parental involvement, returns to home-school, discharges, referrals to outpatient services, and terminations due to parental refusal.

SUMMARY

IDT is a time-limited service for children in crisis.. Expeditiousness by clinicians, teachers, parents, and the child are extremely important in treatment. IDT's emphasis on time-limited treatment also means that more children/adolescents are treated per staff than with longer-term treatment programs. IDT is cost effective. Communities without IDT must rely on more costly means of handling an adolescent/family/school crisis, because they lack a community-based treatment alternative that can provide immediate response to a young person in serious distress. IDT does not require large staffing, but staff must be highly trained professionals. IDT is interdisciplinary, multi-agency regulated, and multi-agency funded. It has linkages to a community's mental health and educational systems, an essential program component for quickly treating emotionally disturbed adolescents experiencing a crisis in school and at home. IDT relies on other community services to provide post-crisis adolescent and family services in the areas of: housing, substance abuse, adolescent/adult mental health. IDT is an equal opportunity program available to children in regular and special education.

Jane Knitzer, in her 1990 publication At the Schoolhouse Door: An Evaluation of Programs and Policies for Children with Behavioral and Emotional Problems, describes Rockland Children's Psychiatric Center's school based collaborative initiatives as "one of the most comprehensive programs that we identified." She goes on to describe IDT as an alternative to hospitalization or homebound instruction, and a program which has "strong support from mental health department, community mental health boards, school superintendents, community school boards, and labor unions".

BK 5/28/93

APPENDIX K
Stark County System of Care

Stroul, B. A. (1992). Profiles of local systems of care for children and adolescents with severe emotional disturbances: Stark County, Ohio. In B. A. Stroul, S. K. Goldman, I. S. Lourie, J. W. Katz-Leavy, & C. Zeigler-Dendy, *Profiles of local systems of care for children and adolescents with severe emotional disturbances* (pp. 1 - 53). Washington, DC: CASSP Technical Assistance Center, Center for Child and Mental Health Policy, Georgetown University Child Development Center.

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PROFILES OF LOCAL SYSTEMS OF CARE

for Children and Adolescents with Severe Emotional Disturbances

Prepared By:

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Funded by the National Institute of Mental Health
Child and Adolescent Service System Program (CASSP)

July 1992

Profiles of Local Systems of Care

for Children and Adolescents with Severe Emotional Disturbances

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STARK COUNTY, OHIO

Prepared By:
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Georgetown University Child Development Center

Funded by the National Institute of Mental Health
Child and Adolescent Service System Program (CASSP)

July 1992

PROFILE OF A SYSTEM OF CARE: STARK COUNTY, OHIO

I. COMMUNITY CONTEXT

The system of care to be described serves children and families of Stark County, Ohio, which is located in the northeastern part of the state. The county is not far from other major Ohio cities, with Akron about 30 miles north, Cleveland about 50 miles north, and Columbus about 120 miles southwest. Stark County is the seventh largest county in Ohio and has a population of 367,585. Half of the county's population is concentrated in the central area which includes Canton and North Canton. While the Canton area is described as urban, the surrounding areas are described as suburban and rural. Within a mere ten minutes of downtown Canton, the landscape shifts to primarily large, rural farming districts.

In addition to the concentration of population in the Canton/North Canton area, Stark County has two additional population centers -- Massillon and Alliance. Due to the distances between the three population centers and the lack of a good transportation system linking them, services are typically offered in each of the three areas. As might be predicted, the Canton/North Canton area boasts the richest array of services, and the service array tends to be less well developed in the Massillon and Alliance areas.

The population of Stark County is predominantly white, nearly 92 percent. Census data indicate that 8.3 percent of the population belongs to minority groups, with most being African American (7.5 percent) and the rest being Hispanic. Much of the county's African American population is concentrated in Canton; approximately 18.2 percent of the population of the City of Canton is African American, and African American children comprise about 30 percent of the student population of the Canton City Schools.

Census data indicate that the median family income in 1990 was $29,425, and about 13.5 percent of Stark County residents had household incomes below the poverty level. Based on a more realistic standard for assessing poverty (incomes below 125 percent of the poverty level), it is estimated that nearly 18 percent of Stark County's families can be considered poor. In fact, poverty in Stark County has increased by 15 percent since 1985, and the county's poverty rate exceeds the statewide average by 20 percent. A significant and growing group in Stark County consists of the working poor.

Historically, Stark County has been a leading manufacturing center. In 1980, the largest industry in the county was manufacturing, which accounted for nearly 36 percent of the county's jobs. Headquarters and plants have been located in Stark County for many large industries including alloy steel, roller bearings, vacuum cleaners, building materials, gasoline and diesel engines, and bank security and transaction technology. Along with the rest of the Midwest, the county has suffered from the scaling back of the steel and rubber industries during the 1970s and 1980s.

While plant closings have resulted in losses in jobs, it was reported that Stark County was not as devastated by the industrial declines as were other areas. This is attributed to greater diversification as well as continued investments by large companies such as Timken Steel.

Despite the economic crisis, the county still has an industrial base. Further, the relatively low cost of living has attracted many new residents, and the Canton/North Canton area has experienced rapid growth over the past 15 years.

Currently, the major employers in the county include Timken Roller Bearing and Specialty Steel, Hoover, Diebold, and Republic Engineered Steel. In addition, large numbers of citizens are employed by two general hospitals (Timken Mercy Medical Center and Aultman Hospital and the Massillon Psychiatric Center, a state hospital serving adults with mental illness. Agriculture also contributes to the county's economic base. Not unlike other midwestern communities, Stark County's economy is moving from a primarily industrial job base to an economy that includes more service occupations as well as manufacturing and agriculture.

The county offers a variety of cultural, recreational, and educational opportunities. It is perhaps best known for the Pro Football Hall of Fame, a significant tourist attraction. Canton was selected at the site for the Hall of Fame because the National Football League was founded there in 1920. There is a strong interest in sports in the area, from the minor league Canton Indians and the professional soccer team, the Canton Invaders, to the sports teams in nearby Cleveland. The community is home to a symphony orchestra, civic opera, ballet company, and players guild and has museums including the Hoover Historical Center and the William McKinley Museum of History, Science, and Industry. Two four-year liberal arts colleges are located in Stark County (Malone College and Walsh College) as well as the Stark Technical College and the Stark County campus of Kent State University.

Stark County faces a number of significant problems. Transportation was among those cited most frequently. The lack of a good public transportation system affects the community as a whole and creates formidable barriers to accessing services. Another frequently cited problem was poverty, particularly the growing segment of the population which can be classified as working poor. Family instability also is perceived as a major problem for the community, since Stark County has one of the higher divorce rates in the state.

In order to explore the needs of community in a systematic way, the United Way of Central Stark County sponsored a county-wide needs assessment which was completed in 1990. Focus groups, telephone surveys, information and referral tabulations, and other data and reports were analyzed to identify needs and rank them in priority order. This process resulted in the identification of priority needs for the county including:

- Substance Abuse
- Parenting/Family Integration
- Mental Health
- Abuse/Neglect
- Emergency Income Assistance
- Short-term Shelter
- Hunger/Nutrition
- Affordable Housing
- Pregnancy/Family Planning
- Day Care
- Transportation

The highest ranked need reflects the community's growing concern about substance abuse. Crack houses have been identified in Stark County, and there has been a 90 to 100 percent increase in the incidence of crack babies in the past several years as well as a significant increase in requests for services related to crack addiction. The Department of Human Services (DHS) reported that 68 percent of all child abuse and neglect cases handled in 1990 involved substance abuse in some way. Of significant concern is the growing incidence of gang violence related to drug abuse, particularly in one section of Canton. Gangs from the Los Angeles area have been identified in the county, a cause for alarm among citizens, law enforcement, and human service providers.

Along with substance abuse services, other needs receiving the highest rankings include supports for parenting and families, mental health services, and services to address child abuse and neglect. The four highest priority needs discerned by the United Way needs assessment process are all directly associated with the current activities of the Stark County system of care for troubled children and families.

The human service system at the state level in Ohio consists of seven cabinet level departments including Departments of Mental Health, Mental Retardation/Developmental Disabilities, Youth Services, Human Services, Health, Education, and the more recently created Department of Alcohol and Drug Addiction Services. While these agencies fund, regulate, and oversee local services, the service system in Ohio is largely county operated with community boards directing and planning service delivery in many of the categorical areas. Thus, the service system environment in Stark County is seen as one of local control and autonomy, with community-level responsibility and decision making.

The following child-serving agencies and systems provide services in Stark County and are key players in the system of care:

- Mental Health: Stark County Community Mental Health Board and Child and Adolescent Service Center
- Child Welfare: Stark County Department of Human Services
- Education: Stark County Board of Education and 17 School Districts with Boards of Education including Canton City Schools
- Juvenile Justice: Stark County Family Court, Regional Office of Ohio Department of Youth Services, and the Stark County Prosecutor's Office
- Health: Stark County Health Department, Canton City Health Department, Massillon Health Department, and Alliance Health Department
- Mental Retardation: Stark County Board of Mental Retardation and Developmental Disabilities
- Substance Abuse: Alcohol and Drug Addiction Services Board of Stark County

During the site visit, no instances were noted suggesting ways in which the state has hindered system development in Stark County. On the whole, it appears that the state has had a positive influence on the course of system development in Stark County by encouraging interagency collaboration and by providing philosophical support and technical assistance.

III. PHILOSOPHY AND GOALS

As noted, the roots of the philosophy of the Stark County system of care can be traced to the children's committee which was instrumental in advocating the formation of a separate children's mental health agency. Though the process began nearly 20 years ago, the basic elements of the philosophy have remained constant over time. Four basic elements appear central to the philosophy of the Stark County system:

- **Interagency Collaboration** - The system of care is based upon the premise that children and families have problems which relate to multiple systems and that no one agency alone can be effective in serving them. The child-serving agencies in the community consistently express the conviction that agencies cannot be as effective individually as they can be together, and that no single agency has either the ability or resources to meet all the needs of a child and family. This philosophy of interagency collaboration has been well-ingrained in Stark County, and interagency participation is evident in planning and service delivery activities.

- **Providing Services within the Home and Community** - A belief in providing services to youngsters within their homes and within the community has been evident throughout the development of the system of care. The choices to develop day treatment and home-based services as alternatives to residential services were based upon a strong philosophical commitment to provide services in the least restrictive setting, to keep youngsters with their families to the greatest extent possible, and to keep youngsters within the county to the greatest extent possible.

- **Family Focus** - A third element of Stark County's philosophy is that the child must be viewed as a member of a family. In this context, a primary role of the system of care is to support positive family functioning. The family-centered approach embraced by the system of care was evident both in documents and in discussions with agency executives and staff. Throughout the planning and delivery of services, the system focuses on the needs of the entire family and on involving parents as partners.

- **Strengths Focus** - Another recurring theme in both documents and discussion is the need to focus on the child's and family's strengths rather than on pathology. This philosophy compels the system of care to seek opportunities to build on strengths, even for the most troubled children and families. An interagency service planning process, used for difficult cases, centers on the identification of strengths that can be employed creatively in the development of service and treatment plans.

The philosophy and principles governing service delivery have been refined over time. The first Cluster retreat, held in 1989, was devoted to articulating the vision and driving principles for the county's system of care. While some communities may struggle to reach consensus on their values and principles, this was characterized as a relatively easy task in Stark County. Many of the elements of the philosophy had been in place for some time, necessitating refinement rather than reinvention. The retreat resulted in the development of a vision statement for the Stark County system:

> "We visualize a unified system that energizes all services around each child's needs so they can realize their maximum potential. This system provides positive alternatives within the community so that the child will have the opportunity to build on his/her strengths. This system effectively supports positive family functioning and nurtures children in a socially, emotionally, and educationally sound environment which persists into adult life."

The driving principles for the system of care developed during the retreat reflect the philosophical commitment to interagency collaboration, providing services within the home and community, focusing on families, and focusing on strengths. These principles include:

- "Identify and accept without exception all those who are in need through a proper and appropriate assessment.
- Child centered and individualized service with a family focus.
- Develop an aggressive program that wraps services around the child's/family's needs and provides whatever services are needed. (Whatever it takes!)
- The community is part of the solution and not the problem.
- Everyone has the right to life, liberty, and happiness.
- Parents of the youth are involved as partners in the definition of issues as well as the solutions.
- Have the least restrictive, community-based services.
- Have community awareness of various systems that provide services to children.
- The focus is on prevention and the child's and family's strengths, rather than pathology.
- Everyone has self-worth, and change can occur.
- The system of care will accept every child no matter what his or her disability with a "no eject, no reject" philosophy."

The goals of Stark County's system of care parallel the elements of its philosophy and include the following:

- To provide a unified system of service delivery.
- To provide services which enable children to remain within their homes and community to the greatest possible extent.
- To reduce the numbers of children in out-of-home and out-of-county placements.

IV. TARGET POPULATION

As the Cluster designed a blueprint for a system of care in Stark County, one of the major issues considered was defining the target population. During the first creative planning retreat, the Cluster generated a set of identifying factors to set parameters for the population to be served. Two primary elements appear to define the target population from the perspective of the Cluster -- multiple needs and difficulty meeting these needs within existing services. Thus, the Cluster defines the target population for the system of care as children with multiple needs and their families for whom current or existing services have been inadequate or unsuccessful. Some of the identifying factors for the target population cited by the Cluster specify youngsters needing multiple systems for support, needing highly specialized or intensive services, at high risk for institutionalization, or presenting as "failures" within individual agencies. In May 1992, the Cluster adopted a formal definition for its target population, specifying the following criteria:

- Stark County resident
- 0 - 18 years of age (through 21 in many cases)
- Involved in at least three child-serving systems (Juvenile Justice, Child Protection, Health, Mental Health, Mental Retardation/Developmental Disabilities, Alcohol and Drug, Experiencing Problems in Education)
- Child's multiple needs must exist within the child's physical, health, medical, emotional, developmental or intellectual functioning as primary obstacles to the child's optimum growth and development.

The target population is further defined by a planning document prepared by the Stark County Community Mental Health Board. Based on discrepancies between the needs of children and adolescents and available resources, the Board proposed priorities for services within the mental health system as follows:

A. Children and adolescents with a mental health diagnosis plus:

    - Long-term psychiatric hospitalization
    - Residential placement
    - Out-of-county/state placement
    - Cluster involved
    - Out-of-home placement

B. Children and adolescents with a mental health diagnosis plus:

- School drop-out/special education placement
- Detention/juvenile corrections facility
- Teen parent
- Homeless/living along
- Foster home
- Drug/alcohol abuse
- AIDS related

C. Children and adolescents with a mental health diagnosis plus at least three risk factors (e.g., low income, single parent family, abused, etc.)

D. Children and adolescents who request services

An additional definitional tool is provided by ODMH which has established criteria for certifying youngsters as severely emotionally disturbed (508K certification). The criteria for such certification specify that youngsters have the following characteristics:

- Age birth to 18 years
- Marked to severe impairment within the past six months
- Impairment which seriously disrupts academic or developmental progress
- Impairment which seriously disrupts family or interpersonal relationships
- Problems leading to the impairment which have lasted six months or longer
- Requires the services of other youth-serving systems, e.g., education, human services, juvenile court, health, MR/DD, and youth services

These definitions appear compatible in that they all emphasize serving youngsters who have multiple needs and are involved with multiple systems, youngsters with serious problems and needing intensive services, and youngsters in or at risk for out-of-home or out-of-county placements of various types.

Data were provided to describe youngsters coming before the Cluster as well as youngsters served by the CASC. A profile of 25 youngsters presented to the Cluster from 1984 to 1989 shows that the majority were male (76 percent) ranging in age from 9 to 19, with the modal age categories being 15 and 16. Nearly 80 percent of the youngsters had IQ scores below 84, and 80 percent came from families which were not intact. An overwhelming majority of the youngsters (88 percent) had previous out-of-home placements, the most frequent of which was at Sagamore Hills Hospital where one-third of these youngsters had previous episodes of psychiatric care. All of the youngsters had previous involvement with multiple agencies; over 70 percent were involved with three, four, or five agencies. These data indicate that the Cluster does appear to be serving youngsters with multiple needs who are at risk for out-of-home placements and for whom existing services from multiple agencies have proven ineffective.

CASC data from fiscal year 1991 suggest that the population served by that agency also falls within established priority groups. More than 85 percent of the agency's 1991 client population was certified as severely emotionally disturbed based upon the state's 508K certification criteria. About 40 percent of the client population had level of functioning scores of less than 50 on the Global Assessment Scale, indicating serious impairments in all spheres. The client population exhibited risk factors as well; more than 40 percent lived in single mother households, and nearly 70 percent were eligible for some type of government entitlement suggesting high levels of poverty. About two-thirds of the youngsters were referred to the CASC by another agency or system, most frequently by the child welfare or juvenile justice systems or by the schools. About 15 percent of the population served by the CASC belonged to minority groups, almost exclusively African American.

V. ORGANIZATION OF THE SYSTEM

System Management

The organizing structure for the system of care in Stark County is provided by the Cluster. Within this framework, all agencies participate in system management in accordance with a deliberate decision not to have a lead agency. The Cluster itself was characterized as the lead agency, a collective body assuming responsibility for planning and overseeing the system of care. The decision not to have a designated lead agency appears to be based upon the assumption that the system would be less effective if one agency took the lead, whereas joint management would lead to joint ownership of the system of care. Further, respondents indicated that with a joint management approach, it is more difficult for individual agencies to "cop out" or shift their responsibility onto another agency. Based upon this approach, responsibility for chairing the Cluster rotates among the participating agencies on a regular basis, every six months. At the time of the site visit, the Executive Director of the Mental Health Board was serving as Cluster Chair to be followed by the Administrator of the Family and Children's Services Unit (the Cluster representative from DHS.)

Until recently, Stark County did not received any special funding to support the operations of the Cluster. The Cluster functioned within the administrative budgets of participating agencies. For example, Cluster meetings are held in the conference room of the Mental Health Board, and the Mental Health Board also has provided secretarial support for Cluster activities. The Cluster considered potential funding opportunities for a cluster coordinator position to manage Cluster activities and coordinate activities related to the system of care. A number of options were explored including approaching the County Commissioners to provide funds for such a position and blending funds from the participating agencies for this purpose. When the Mental Health Board recruited a Children's Coordinator, this individual naturally began to assume some of these coordinating functions. Ultimately, the Cluster decided that the Children's Coordinator from the Mental Health Board would fulfill the role of cluster coordinator, and, as a result, the need for a separate cluster coordinator position has diminished. In December 1991, the Cluster and Mental Health Board officially recognized that the Children's Coordinator was, in fact, serving as cluster coordinator. Subsequently, a grant proposal was submitted to the State Level Cluster, and funds were received to support 50 percent of the salary of the Children's Coordinator in recognition of the crucial role she fulfills for the local Cluster.

Role of Participating Agencies

- Mental Health: Stark County Community Mental Health Board and Child and Adolescent Service Center (CASC)

  The Stark County Community Mental Health Board serves as the administrative and fiscal monitoring agent for mental health services in Stark County. The Board contracts with various provider agencies in the community for mental health services for children and adults. Unlike mental health boards in many other communities, the Stark County Board has had a long-standing commitment to children's services. This is evidenced by its decision in 1975 to create a separate children's agency and in its provision of support and resources for the development of a service array for children. In 1990, a new position was created at the Board for a Children's Coordinator, further solidifying the Board's commitment to building the county's system of care. The Children's Coordinator plays a key role in coordinating the activities of the Cluster and planning for the system of care.

  The major contract agency of the Mental Health Board for children's services is the CASC. The CASC, founded in 1976, currently employs approximately 30 professionals, has a budget of over $2.6 million, and is accredited by the Council on Accreditation for Services to Children and Families, Inc. The CASC offers a wide range of mental health services including individual, group, and family counseling; psychological testing; psychiatric evaluation and medication services; day treatment; case management; child management groups; consultation, education, and prevention services; intensive home-based services; and services for victims of child sexual abuse as well as for youthful sex offenders. From its inception, the CASC has reached out to other child-serving agencies, involving them on its board and other advisory structures. Thus, other community agencies have played active roles in establishing directions for the CASC's continued development. A perennial problem for the CASC has been a high demand for its services as compared with its service capacity. The result has been a wait list for most programs and an ongoing tension between the desire to serve more people versus the desire to provide highly intensive and effective services to those judged most in need. As the primary service provider agency for children's mental health in the county, the CASC also is represented on the Cluster.

- Child Welfare: Stark County Department of Human Services (DHS)

  The Social Services Division of the Stark County DHS provides a variety of child welfare services. Intake units provide protective services for children by investigating reports of alleged child abuse and neglect, with over 3600 referrals investigated in 1990. In cases of alleged sexual abuse and abuse cases with potential criminal involvement, teams of sheriffs and social workers are assigned to conduct investigations jointly. Family service units provide protective services on an ongoing basis to families requiring continued supervision and intervention in order to insure the well-being of children and to maintain the family unit.

  In addition to protective services, a range of child placement services are offered by DHS. Foster care services include recruiting, licensing, and training foster families and providing supervision and case management for youngsters in foster care. A group home system with two homes for boys and two homes for girls is operated in the county, with approximately 30 children in group home care at any given time. Most children in the group homes have some degree of emotional or behavioral problem. DHS contracts for residential treatment for youngsters needing specialized treatment for emotional disorders. An adoption unit provides services to children who are legally free for adoption. Other services provided by DHS include a shelter system, parent aide services, single parent services, and day care services.

In 1990, a children's services levy was passed in Stark County. The levy will create a stable base of funding for the delivery of children's services for a five-year period. Respondents indicated that the passage of the levy demonstrated the commitment and concern of the general public about the needs of children and families in the community.

o Education: Stark County Board of Education and 17 School Districts with Boards of Education including Canton City Schools

Stark County contains 17 autonomous school districts, each with its own board of education and superintendent. County-wide, over 12,000 children are identified as needing special education services. Most of the local school districts provide special education services for high incidence problems. For low incidence disabilities, services are provided by the Stark County Board of Education. Among the county-operated special education units are classrooms for youngsters with severe behavioral handicaps. The County Board of Education contracts with the CASC to provide a psychologist to consult with teachers and provide group counseling for youngsters in special education classes. The Stark County Board of Education also provides school psychologists and other specialized services that the smaller districts cannot afford individually. The County Board of Education is represented on the Cluster.

The largest of the local school districts is the Canton City Schools. The Department of Special Education offers a comprehensive range of special education and related services and supports for all handicapping conditions, including a severe behavior handicapped program. The Canton City school system participates actively in the Cluster process and the system of care. For example, the Day Treatment Program, which is accessible to all children in Stark County, is a collaborative program between the Canton City Schools, the CASC, and DHS. In addition, the Director of Special Education attends Cluster meetings and has taken responsibility for sharing information with the other school districts through regularly held roundtables for special education directors. Representatives of other school districts typically participate in the Cluster process on an individual case basis, but are less actively involved in system planning and coordination activities.

Several activities have been undertaken to improve both regular and special education in the community. One of these involved forming a task force with multiagency representation to identify the problems involved in serving children with emotional problems and to develop recommendations. One result of this Severe Behavioral Handicapped Task Force was a proposal to develop a collaborative program between the schools, court, and mental health agencies to serve youngsters with conduct disorders for which funding is still being sought. Another activity was sponsored by a foundation in Stark County, the Education Enhancement Partnership, which allocated $3 million in 1990 to improve education in the county. The funds are being used in a public/private partnership to assess needed improvements in the county's educational system and to develop plans. The planning process has emphasized the need to look beyond the six-hour school day and work toward strengthening families as well as the need for early identification and intervention for special needs.

o Juvenile Justice: Stark County Family Court and Regional Office of Ohio Department of Youth Services

The Stark County Family Court consists of the Juvenile Court and Domestic Relations Court and has three judges. The Family Court presents its mission as "protection and welfare of the community by providing a network of services and innovative programs for families and youth through cooperation with community agencies in an effort to make juveniles and families more responsible and accountable." To fulfill this mission, the court offers a range of services which are directed at prevention, diversion, and alternatives to institutionalization. These include intensive probation services provided by a probation officer who is skilled in parent effectiveness training; courses in parent effectiveness; in-home detention involving short-term, intensive support and monitoring for offenders as an alternative to incarceration; restitution programs providing supervised work for youth which allows them to compensate victims; and job skills training programs for youth at risk. Services for sex offenders are a priority for the court since there has been a substantial increase in the number of youths involved in sex offenses in recent years. Services include those of a probation officer trained in working with sex offenders as well as diagnosis and treatment offered in conjunction with the CASC. Additionally, prevention programs that stress responsibility and law are provided in the schools for youngsters in third, fourth, and fifth grades. The juvenile justice system in Stark County also includes residential options both provided and purchased by the Family Court.

The Multi-County Juvenile Attention Center, which is located in Stark County, serves as the detention facility for a five-county area. A council of governments was formed by the counties to administer the facility. The regional office of the Ohio Department of Youth Services provides funding for many of the Family Court programs as well as monitoring local service delivery. The Department of Youth Services also assumes custody of youthful offenders upon commitment by the Juvenile Court for felony level offenses, thereby transferring responsibility from the county to the state agency.

o Health: Stark County Health Department, Canton City Health Department, Massillon Health Department, and Alliance Health Department

The health departments in Stark County provide a variety of services available to children and families. Public health nurses conduct physical assessments which include evaluation of growth and development for infants and children through age 18. Childhood immunizations are provided as well as testing for various communicable diseases such as tuberculosis. Diagnosis and treatment of sexually transmitted diseases is another important function of these agencies, along with follow-up on sexual contacts and education regarding the prevention of sexually transmitted diseases. Increasingly utilized services are testing and counseling for HIV infection and education regarding the transmission and prevention of AIDS. The health departments fulfill a variety of health education functions by providing information and educational programs in many settings including schools.

- Mental Retardation: Stark County Board of Mental Retardation and Developmental Disabilities (MR/DD)

  The Stark County Board of MR/DD was formed in 1968 and provides a "lifetime of services" to people of all ages with mental retardation and developmental disabilities. The MR/DD Board operates seven facilities and provides a range of programs including Early Childhood Intervention, Schools, Adult Services, Family Resources, Case Management, and Social Services.

  In 1991, the MR/DD Board adopted a new population definition as required by the state. The new definition expanded the population to be served by the agency by raising the age limit for services from 18 to 21 and by emphasizing substantial functional limitations in determining eligibility. The new definition was presented and discussed at the Cluster meeting.

- Substance Abuse: Alcohol and Drug Addiction Services Board of Stark County

  In 1990, Governor Celeste created a new Department of Alcohol and Drug Addiction Services at the state level. Counties were given the option of having a separate board to plan and oversee substance abuse services or of consolidating this function under their mental health boards. In the majority of Ohio counties, the substance abuse function is combined with mental health under the authority of a single board. Stark County, however, is one of eight counties that elected to have a separate board for substance abuse services.

  The Alcohol and Drug Addiction Services Board of Stark County was formed in 1990 with the mission to plan, fund, and evaluate alcohol and drug addiction services in the county. As part of its planning responsibilities, a needs assessment was conducted and a five-year plan for substance abuse services was developed. The Alcohol and Drug Addiction Services Board provides funds to Quest Recovery Services, which is the major substance abuse provider agency serving children and adolescents.

In addition to these major child-serving systems, a number of other agencies participate in the system by providing services to youth and families and through their involvement in the Cluster. These agencies include:

- Lincoln Way Special Education Regional Resource Center
- Job Training Partnership
- Ohio Rehabilitation Services
- Stark County Prosecutor
- Early Childhood Collaborative

As in most communities, some agencies within the system assume an especially active role in the organization and operation of the system of care. Other agencies are less active participants and assume a more peripheral role in system activities. Thus, although there are continual efforts to enhance the involvement of all agencies, Stark County has a core group of agencies which are central to system management and service delivery.

VI. SYSTEM OF CARE COMPONENTS

Outpatient Services

The CASC provides a range of outpatient assessment and treatment services; these are considered to be the least intensive treatment option. Outpatient services are offered through offices of the CASC in Canton, Massillon, and Alliance as well as at an alternative school location established for enhanced accessibility to minority families. During fiscal year 1991, outpatient services were provided to more than 700 children and their families. According to data derived from the Global Assessment Scale, approximately 80 percent of the youngsters receiving outpatient services from CASC are considered to have severe emotional disturbances.

Outpatient services typically begin with a multifactored assessment which is conceptualized in two phases: the intake assessment and the clinical assessment. The intake assessment involves gathering basic data in order to determine the reason for admission, presence of life threatening situations, need for a physical examination, preliminary treatment goals, and an indication of what services might be needed. A clinical assessment is completed by the assigned therapist and covers history, current functioning, and strengths and weaknesses in a variety of domains. The assessments conducted by CASC may require multiple sessions and emphasize family and ecological factors. When necessary, psychological and psychiatric evaluations are used to aid in the diagnostic process. Psychological evaluations are used extensively for youth sex offenders referred by the Juvenile Court to assist it in judicial or placement decisions. The assessment process generally culminates in a treatment plan that is developed collaboratively with the parents and youngster as appropriate.

Individual and family therapy also are offered by the CASC. These services typically consist of office-based counseling appointments which take place once or twice a week depending upon the need. The CASC is working towards increasingly providing its outpatient services in natural environments such as the home, school, or community centers. In fact, a goal for 1992 is for 50 percent of all outpatient services to be delivered in such natural settings rather than in CASC offices. Specialized outpatient services are available for youngsters who are dually diagnosed as mentally retarded/developmentally disabled and emotionally or behaviorally disordered. These services involve counseling to children and families as well as classroom consultation. In addition, a variety of groups are offered. For youngsters, group counseling opportunities include social skills groups, sexual abuse groups, and groups on human sexuality. For parents, child management, communication, and assertiveness training workshops are offered as well as groups for parents of preschoolers, parents of teens, teen mothers, single parents, and parents of youngsters with attention deficit hyperactivity disorder.

Outpatient psychiatric services also are offered by the CASC. A child psychiatrist works at the CASC for a total of two and a half days per week, offering diagnostic assessment and consultation. Psychiatric referrals are made for psychiatric evaluation and for prescription and monitoring of medications. In addition, the psychiatrist provides consultation to other CASC programs. Recruitment of child psychiatrists has proven difficult for the CASC, and the wait for a psychiatric appointment may be as long as six to eight weeks. The Cluster is actively recruiting a full-time child psychiatrist to work both at the CASC and the Crisis Center.

While many of the youngsters involved in outpatient services improve, staff acknowledge that many have serious problems and would benefit from more intensive service options. However, the more intensive service options are difficult to obtain due to wait lists. Wait lists are a problem for outpatient services as well; there may be a delay of as much as seven or eight weeks to get an outpatient appointment. In order to serve those most in need, the CASC attempts to prioritize cases based upon seriousness, providing services to youngsters at risk for harm to themselves or others or those returning from out-of-home placements as a first priority. Additionally, limits on length of stay in treatment have been considered as a way to extend services to more youngsters.

Prevention and Early Intervention

An assortment of programs and services included in the system of care fall into the general category of prevention and early intervention. For example, the CASC operates the Peer Listening Program which involves training and supervising adolescents age 15 to 17 to serve as peer listeners. The trained teens offer confidential active listening, support, information, and referral to other adolescents to help them to resolve or explore solutions to their problems. The CASC provides training to groups of 20 to 25 adolescents at a time and focuses on developing communication and helping skills.

Another program is entitled "Friends Can Keep You Healthy" and is a collaborative effort between the CASC and the Canton City Schools. The program involves biweekly support meetings for a small group of elementary school youngsters in several inner city schools. The youngsters considered for inclusion in this program exhibit mild behavioral or socialization problems. It is anticipated that the support meetings will promote more positive feelings among the youngsters toward themselves and others and will reduce the likelihood of more serious problems.

An "At-Risk Dropout Prevention Grant" received by the Canton City Schools also targets high-risk elementary schools in an effort to minimize future mental health and educational problems. The grant funds therapeutic services in the schools on an individual and group basis for students as well as groups for parents. Behavior adjustment classes are a part of this project and involve developing a behavioral plan for a particular child with parent involvement. These behavioral plans are then implemented with the assistance of behavioral adjustment coaches. Additionally, a school pride incentive program provides tangible rewards and incentives for youngsters who follow the rules.

Early intervention activities in Stark County are coordinated by the Early Intervention Collaborative, a multiagency group which coordinates early intervention services for youngsters from birth to two years. The Collaborative attempts to identify children at-risk for all types of problems at an early age through a centralized resource called the Kids Connection. In addition to early identification, the Collaborative provides developmental information to parents, referrals for services, and parenting classes.

Early intervention activities for children age three to five are coordinated by the local school districts. The Canton City Schools operate preschool programs for at-risk children, including those at risk for emotional disorders, and the CASC provides the mental health component of the community's Head Start Program. The Stark County Board of MR/DD Board also serves a population of children age birth to five who are at risk. For infants and toddlers, a teacher-based service is offered along with individualized occupational therapy, physical therapy, and speech and language therapy as needed. For preschool-age youngsters, an integrated preschool is provided along with several other preschool and day care options for at-risk children.

A unique Preschool Community Services Program is provided to children from birth to five years of age, with a major focus on children with emotional disturbances. The program offers home-based services and consultation in normal preschool settings and provides both clinical and case management services. Until July 1991, these youngsters were served within the Preschool Day Treatment Program which utilized a combined center-based and home-based approach. At this time, the new approach of the Preschool Community Services Program was adopted, and staff was redeployed to attempt to work with these young children in more natural environments including their homes and regular preschools. Following the first full year of operation, the approach is being assessed to determine the continued feasibility of "mainstreaming" these preschoolers. A more specialized setting may need to be reconsidered for some children who present particularly challenging problems and behaviors.

Home-Based Services

The Stark County system of care includes both short-term and longer-term home-based services. The short-term program, Therapeutic In-Home Emergency Services (TIES), was initiated in 1986 as a joint program between the CASC and the Crisis Intervention Center of Stark County. As a result of administrative complications, the program is now operated solely by the Crisis Center, but it remains closely coordinated with the CASC and with other components of the system of care.

TIES is a crisis-oriented program which serves youngsters with serious emotional or behavioral problems who are at imminent risk for out-of-home placement. In order to be eligible for TIES services, the parents must have the desire to keep the family together and be willing to participate in the home-based intervention. The goal of the TIES program is to prevent out-of-home placement by working toward solving problems within the home and family. Like most home-based programs, TIES therapists are available 24 hours a day, seven days a week; the intervention takes place primarily in the home; and visits are scheduled at the family's convenience. Therapists work with only two families at a time, allowing for highly intensive and flexible services for each family. Therapists typically spend an average of six to 10 hours per week with a family; service intensity may reach as high as 20 hours per week with a family depending upon the need. Services are based on an individualized treatment plan for the child and family and include crisis intervention, individual and family therapy, case management, and a range of support services tailored to each family's needs. The program was started with a service duration of six to eight weeks, but found that this was not sufficient time to respond to a crisis and adequately link the family with ongoing services. As a result, the time frame was expanded to 12 weeks. If families experience further difficulties at some point following completion of a TIES intervention, they may call to request additional services. Program staff visit may the families to provide "booster shots" and continue to remain available by phone for continued support.

The longer-term home-based service program is called Intensive Home-Based Services and is operated by the CASC. The priority target group for this program is comprised of youngsters who are or have been in out-of-home placements for treatment purposes and are not likely to reunify successfully with their families without assistance. Accordingly, the program emphasizes serving children who are returning home from long-term psychiatric care or other residential placements. The Intensive Home-Based Services program is staffed by master's level therapists, each of whom works with a caseload of approximately four families. Caseloads may exceed four if a family is transitioning out of the program and needs a relatively low level of services; caseloads may be reduced if a therapist is working with a family requiring highly intensive intervention. In some cases, two therapists may be assigned to a particular family for either therapeutic or safety reasons such as the potential for violence or abuse. Therapists are available 24 hours a day and work with families for an average of one year, although the duration of services is flexible depending upon the family's needs.

The program is designed to stabilize, maintain, and strengthen families and to assist them to function to their maximum potential within the community. It is described as a "clinical model" which involves an assessment of each family's strengths, weaknesses, and service needs; a treatment plan unique to the identified and prioritized needs of each family; the provision of therapeutic services in a natural and nonthreatening setting that focus on functioning within the family system; and linkages to community resources. In addition to individual and family therapy, therapists perform "case management" functions including helping families to meet basic needs, accessing needed services and resources, and helping families in concrete ways -- in short, doing whatever needs to be done to assist the family. When a family is stabilized, concrete needs are met, and there is a low risk of out-of-home placement, transition plans are then developed to link the family with other ongoing services. At minimum, case managers follow families when home-based services are discontinued. Families experiencing further difficulties following termination may be referred for additional home-based services. The program reassesses these families and attempts to meet their needs either by consulting with the staff currently involved with them (e.g., outpatient therapist or case manager) or by short-term reentry into the program with clearly specified goals. To date, no child served by the program has been returned to long-term psychiatric or residential care.

At the time of the site visit, there were 20 families on a waiting list for the Intensive Home-Based Services program; 10 families currently are waiting for these services. Staff use creative approaches for coping with the high level of demand for services such as consulting with other staff who are working with the family at the time of referral or even doing home visits with outpatient therapists to assist them in working more effectively with particular families.

Day Treatment

The Day Treatment Program in Stark County serves youngsters ranging in age from five to 17. The program is designed to serve children who are experiencing severe emotional, behavioral, and/or social problems to the degree that they cannot be adequately treated with less restrictive therapeutic or educational services. The program is a collaborative effort between the education and mental health systems (the CASC, the Canton City Schools, and the DHS) and is described as psychoeducational. Its educational philosophy and structure is based on the Positive Education Program (PEP), which draws upon the philosophy of Nicholas Hobbs and emphasizes positive achievements as opposed to negative behaviors. A level system is used in each classroom and is adjusted to the maturity, cognitive ability, and social awareness of the students. Multidisciplinary treatment teams provide services to youngsters in day treatment, and a wide variety of specialized services are arranged to meet the needs of individual youngsters. Family involvement and participation is considered an essential element of the program. A summer program is offered for eight weeks for all age groups, and the average length of stay in Day Treatment is approximately 18 months.

The School-Age Day Treatment Program consists of four classrooms which serve a maximum of 28 youngsters from kindergarten through high school. Many of the youngsters have been hospitalized at Sagamore Hills or are being diverted from such a placement; more than 70 percent of the youngsters in Day Treatment have been in a hospital or residential treatment center at some time. The vast majority have had multiple school placements, and many are involved with the juvenile justice system. Thus, the Day Treatment Program serves a group of youngsters with extremely serious problems, comparable to the population once served by the state hospital and other psychiatric treatment settings.

In order to be eligible for the program, a youngster must be age five to 17; exhibit severe behavioral, emotional, and/or social disorders; be eligible for enrollment in a Severe Behavior Handicapped Unit as defined by Ohio Department of Education criteria; and be unable to function in a public school setting among other criteria. A structured level system is used in each classroom emphasizing positive reinforcement, and a multidisciplinary team provides a range of services and support to the youngsters and their families. Mental health services include individual, group, and family therapy. A parent group assists parents by providing information on management techniques and an opportunity for mutual sharing and support. In addition to the mental health and educational services which form the core of the program, the youngsters receive extensive case management services, social skills groups, recreational services, speech and language programming, and other related services. A psychiatrist works with the program for approximately six to eight hours each week providing consultation to staff, observing in classrooms, and seeing individual youngsters. Approximately one-third of the children in the program are on some type of medication.

While the average length of stay is 18 months, the program is flexible and willing to make decisions based upon the needs of each individual youngster. An attempt is made to move youngsters into more normalized educational and treatment settings if possible. However, if it is clear that an extended stay in the Day Treatment Program is best for a child, the program will allow the youngster to stay. Transitions back to regular public schools are handled gradually, beginning with a visit and tour. Reintegration may begin with attendance at the school one day per week, with gradual increases over time. Case management and outpatient mental health services are continued both during and following the transition out of Day Treatment.

The longest waiting list for the Day Treatment Program is for older adolescents, the age group which is also considered the most difficult to serve. The program is attempting to provide additional vocational programming and independent living skills training to better serve this age group.

At the time of the site visit, day treatment services included a Preschool Day Treatment program accommodating a maximum of 24 children age two and a half to six years. The program served all of Stark County, with transportation provided by Goodwill, and it operated five days a week, six hours per day. The admission criteria for the program specified that preschoolers exhibit severe behavioral, emotional, or social problems; that they did not benefit from previous services in outpatient mental health or other community settings; and that they have had a complete medical screening. The program utilized a highly structured level system coupled with school readiness activities, socialization groups, and individual therapy when appropriate. Parents were closely involved in all aspects of the program. In addition to home visits by staff, parents come into the program to observe their children, spend time with therapists, attend family therapy session, and accompany youngsters on field trips.

A unique aspect of the Preschool Day Treatment Program was the development of a combined center-based and home-based approach for the majority of youngsters. One group of preschoolers attended the five-day school program. Two additional groups were involved in an intensive preschool home-based program. This approach was developed in recognition of the difficulty in translating gains in the treatment setting to the home environment. It was decided to reduce the amount of time children spent in the center to two days per week and to provide a therapist, called an "early childhood interventionist," to visit families at home once or twice weekly for one to two hours depending upon the family's needs. The interventionist worked with families on child development, behavior management, nutrition, homemaking skills, and obtaining needed services and supports. The success of this combined center and home-based approach led to the decision to transform the Preschool Day Treatment Program into the Preschool Community Services Program. Staff were redeployed to work with these youngsters in more natural settings including their homes and regular preschools. The interventionists provide clinical and case management services to the children and their families as well as consultation to the preschools that the children now attend. The new approach, adopted in July 1991, currently is being evaluated with particular attention to the feasibility of mainstreaming these preschoolers with emotional and behavioral disorders. Consideration may need to be given to reestablishing a more specialized setting for some youngsters who present particularly difficult challenges.

Crisis Services

Mental health crisis services in Stark County are provided by the Crisis Intervention Center of Stark County, a free-standing, nonprofit agency. The Crisis Center is funded primarily by the Mental Health Board and serves as a county-wide emergency services system. The agency characterizes its purposes as providing crisis intervention in the community, decreasing the need for hospitalization, and assuring appropriate use of community resources.

The Crisis Intervention Center is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO).

The Crisis Center was started in 1970 as a crisis telephone hotline staffed by volunteers. Although volunteers are still utilized for the hotline, the Center now relies on staff who are specialized and highly skilled in handling crises. The agency recruits staff who are well suited for crisis work and boasts an average staff tenure of about 7.5 years, a noteworthy accomplishment in the area of crisis services where burnout is prevalent.

The Crisis Center offers a range of crisis services. Telephone crisis services are offered through a 24-hour hotline answered by staff with the assistance of volunteers. Volunteers receive 48 hours of classroom training as well as close supervision to prepare them for this role. Through the hotline, the Crisis Center provides after-hours phone coverage for all contract agencies of the Mental Health Board and for other agencies as well. The CASC, the three adult mental health centers, and the substance abuse treatment agency in the county all rely upon the Crisis Center for after-hours telephone coverage. The DHS child abuse/neglect report line and Parents Anonymous are among the other agencies and groups utilizing the Crisis Center's telephone crisis services. The Crisis Center has estimated that approximately 20 percent of its calls are related to children.

Face-to-face crisis services also are provided, primarily on an outreach basis. The philosophy of the agency involves going out to where the crisis is occurring in order to intervene most effectively. The Crisis Center estimates that more than half of its outreach services involve children and adolescents and their families. Individual staff members perform outreach services 24 hours a day; a team which includes a psychiatrist may respond when hospitalization is a potential disposition. Walk-in crisis services also are available at the Center, along with a number of groups such as a treatment group for men involved in domestic violence, a group for persons who have lost someone through suicide, and a support group for people with HIV or AIDS and significant others.

In cases involving children, the Crisis Center works closely and cooperatively with the CASC. Home-based therapists and case managers are available 24 hours a day and can be contacted if crises involve their clients. In other cases, particularly in serious clinical emergencies, the Crisis Center's staff handle the crises directly. Where there is a question of psychiatric hospitalization, the Crisis Center contacts CASC staff members who are responsible for the screening, assessment, and procedural arrangements. In order to ensure continuity of services, the Crisis Center prepares a list of clients with whom they have had contact for each of the participating agencies. This list is faxed daily to each agency including the CASC. If the client has a case manager, the crisis worker calls the case manager to provide information about the crisis contact.

Anther type of crisis service is observation beds at the Crisis Center which provide an opportunity for brief respite, further observation, and stabilization. At the time of the site visit, only two such beds were available for both adults and children, and there was universal agreement that two beds for the entire county was insufficient to meet the need. In fact, respondents agreed that a missing component in the system of care is some type of short-term, crisis residential option for children. In response to this need, the Mental Health Board and Alcohol and Drug Addiction Services Board are providing funds for an expanded capacity for crisis residential services. The third floor of the Crisis Center is undergoing renovation to serve as a short-term residential crisis option with 12 beds. A separate section with four beds has been designated to provide short-term crisis placements for children and adolescents. The new crisis residential services should be operational by August 1992.

Child and Family Advocacy Program

In response to the growing problem of child sexual abuse in the community, a working coalition of agencies formed in 1986. The coalition included DHS, the Juvenile Court, the Mental Health Board, the CASC, the Crisis Center, Junior League, law enforcement agencies, and others and resulted in a plan for a program to provide assessment and therapeutic services related to sexual abuse. A grant application was prepared by the Crisis Center, and funding was received from the Victims of Crime Act to initiate the program; the CASC received additional monies to supplement the program. Thus, the Child and Family Advocacy Program was started in 1987 as a joint program of the Crisis Center and CASC.

Due to complex administrative problems, the funding was ultimately combined and the program unified under the administrative auspices of the CASC. Currently, the Child and Family Advocacy Program conducts assessments of sexual abuse situations including psychological evaluation of the child, assessment of the ability of a child to testify, veracity of allegations, potential effects of a court hearing on the child, and child placement issues. Staff provide therapeutic services including individual and family therapy for as long as necessary. Group treatment also is offered including a teen support group and a mothers group. Services provided by the program are limited to nonoffending family members with offenders referred to other treatment resources. In addition, the program advocates for the child with other agencies, including attending regular meetings with the prosecutor handling the child's case to assist in decision making at each stage. The program also has an educational function, conducting seminars and preparing brochures and other materials to assist teachers and other agencies to identify and respond appropriately to situations which may involve sexual abuse.

Substance Abuse Services

The primary provider of substance abuse services to children and adolescents in Stark County is Quest Recovery Services. Quest's major service is its Intensive Adolescent Outpatient Treatment Program, which consists of daily programming from Monday through Friday from 4:00 P.M. to 8:00 P.M. for a period of more than four weeks. This program provides individual counseling, family and group therapy, personal growth/self-awareness activities, refusal skills, lectures and speakers, videos, group discussions, and access to medical services. Following this initial intensive program, a 12-week continuing care program is provided which offers emotional support to adolescents and their families and encourages continuing personal growth. A complete assessment, including a physical examination, is required prior to admission to the program. In addition to the Quest's services, a number of area hospitals offer substance abuse treatment on an inpatient basis.

Youth Sex Offenders Program

The Youth Sex Offenders Program is a joint program of the Stark County Family Court and the CASC. The program focuses on adolescents who are already adjudicated adolescent sex offenders or youngsters with problems severe enough to place them at high risk for this outcome. The services begin with a diagnostic assessment, a major component of which is a community risk assessment used to determine the safety of working with the youngster in the community. If the risk is deemed too high, a secure treatment setting is sought. Unfortunately, there is no secure treatment program for sexual offenders within Stark County.

For those adolescents who can remain in the community, the program provides counseling and psychotherapy on an individual and group basis. A group for youth sex offenders is co-lead by a mental health therapist from the CASC and a probation officer, both of whom have received highly specialized training in this area. The program is seen as an alternative to more costly and restrictive institutional placements and serves approximately 25 children per year. As of fiscal year 1992, none of the youngsters have committed additional offenses while involved in the program.

Respite Services

The major provider of respite services is the Tri-County Easter Seals Society. Easter Seals offers in-home respite utilizing trained adults as providers, out-of-home respite in the provider's home, and emergency respite. The trained respite providers provide families with a much needed break from the physical and emotional demands of caregiving. In the past, Easter Seals respite services were available only to individuals with mental retardation or developmental disabilities. Respite services have been expanded to serve families of youngsters with serious emotional disorders and adults with severe mental disabilities. For children, arrangements for respite services are handled on an individual case basis and typically are purchased by the Cluster or the CASC. Respite providers with Easter Seals receive over 40 hours of specialized training related to the needs of developmentally disabled and/or mentally disabled populations. Easter Seals is working with the CASC to develop a training package for respite workers that is specifically geared toward working more effectively with children who have emotional disturbances.

In addition, a list of independent on-call support persons has been prepared by the CASC. These persons can be contacted as needed to provide respite or other types of support to children and families. A goal is to computerize this list of on-call support persons and make it available to all Cluster participants. In addition, a training program for these support persons is being developed.

Residential Services

Youngsters requiring treatment in residential settings have access to a number of placement options. Ohio Mentor provides some therapeutic foster care services in the county, but these have primarily been targeted for children with mental retardation. The Stark County DHS operates a system of group homes which serve youngsters with emotional or behavioral disorders. Residential treatment options used by the Stark County system of care are all located outside of the county and include such facilities as Berea Children's Home, Marycrest, Parmadale Family Services, and Beechbrook, all located in Cleveland, and Smithville Boys Village in Wooster. When a Stark County youngster is in any of these facilities, a liaison from the county is assigned to work with the child and the therapist to ensure that high quality services are being provided. An attempt is made to visit each child in out-of-county placement at least once per month.

Inpatient psychiatric services are provided by Timken Mercy Hospital which is located in Stark County and has a specialized adolescent psychiatric unit. Aultman Hospital, also located within the county, does not have a separate children's unit but does on occasion admit adolescents over age 16 to its psychiatric unit. A psychiatric unit for children and adolescents also is available at Akron Children's Hospital Medical Center, approximately 30 miles away in neighboring Summit County. Sagamore Hills, located in Cleveland, is the state psychiatric hospital for children. The hospital serves adolescents ages 12 to 18 who are harmful to themselves or others. The hospital has been significantly downsized, however, and the state plans to transform it into community-based programs. Residential and psychiatric hospitalization are paid for with Cluster funds unless there are other sources of funding, such as Medicaid or insurance, which are drawn upon first.

System Needs and Gaps

Stark County has systematically built the service array included in its system of care. In particular, the community has attempted to increase the array of intensive, nonresidential services such as home-based services and day treatment. The expressed purpose of creating intensive, nonresidential service options has been to reduce the need for out-of-home and out-of-county placements. Despite noteworthy progress in building the array of services included in the system, service gaps remain. There appears to be widespread agreement that three services in particular are critically needed.

The first of these services is therapeutic foster care. At the time of the site visit, some therapeutic foster care services were purchased, primarily by DHS, from several private agencies. Many of these treatment homes were not within Stark County, and there was a great deal of skepticism about the quality and intensity of the treatment services they provided. As a result, therapeutic foster care was not utilized to the extent possible as a less restrictive residential treatment resource for the Stark County system of care. At the time of the site visit, the participating agencies were considering how the capacity to provide therapeutic foster care should be developed in Stark County and which agency should take the lead role. Options under consideration included continuing to purchase therapeutic foster care, but expanding such resources within the county and enhancing the quality of services, or selecting one or more agencies, such as DHS or the CASC, to develop therapeutic foster care services for Stark County. Ultimately, the Cluster made the decision to approach a private provider of other residential services (groups homes and regular foster care) with the possibility of developing therapeutic foster care services for youngsters served by the Cluster. The provider, Pathway, responded favorably and worked with the Cluster to develop plans for therapeutic foster care services. Together, the Cluster and Pathway approached the Stark and Deuble Foundations for financial support and received $50,000 in grants for program development. A coordinator for the program has been hired, and recruitment and training of treatment parents is planned for the summer of 1992. The Cluster plans on purchasing therapeutic foster care services from Pathway on an individual case basis; access to the therapeutic foster care beds will be restricted to the Cluster process.

Respondents indicated that a second priority need for the county was for a crisis residential resource for children. As noted, the Crisis Center had two crisis beds on its premises which allowed for overnight support and observation. However, these beds were shared with the adult service system and were much in demand. In many crisis situations involving children and adolescents, therefore, there was no resource for a short-term residential placement for crisis intervention and stabilization. The lack of such a resource resulted in the use of hospitals and other settings, such as the Attention Center or DHS shelter, for crisis stabilization purposes. There was considerable agreement that the addition of a short-term crisis residential program of some sort would provide a more appropriate and effective resource for youngsters.

Similar to the progress achieved in addressing the need for therapeutic foster care, the community has made progress in filling this gap as well. A new crisis residential program operated by the Crisis Center is slated to open in August 1992, and four beds in a separate area have been reserved for children and adolescents who require a short-term placement for crisis intervention and stabilization purposes. In addition, the CASC has identified a cadre of on-call support persons who can be enlisted to provide support during a crisis in youngsters' homes or in other settings. Further, two providers (Mentor and Easter Seals) now have the capacity to provide short-term crisis respite services in therapeutic foster homes for up to 90 days. Finally, the Cluster has decided to lease a two-bedroom apartment for use in crisis situations. The apartment will be staffed as needed with on-call support persons, and the CASC will provide professional staff to work with the children and their families.

A third need mentioned by many respondents is services for sex offenders. The Stark County system of care has been struggling to determine the types of services that would be both secure and effective in treating this growing population. The dual mission of such services would be to protect the community while at the same time attempting to rehabilitate the youthful offender. The system of care does include an outpatient program to work with sex offenders, but this does not meet the needs of those youngsters who present some risk to the community and who require a more secure treatment environment. In response to this need, the Cluster organized a work group on sex offenders. The work group planned to consult with experts in the area of youthful sex offenders for assistance in conceptualizing and designing appropriate services for these youngsters.

In addition to these priority system needs, respondents noted a number of other service gaps. These include:

- Expanded capacity in all service components (e.g., outpatient services, home-based services, day treatment, and case management) to more adequately meet the needs.
- Transition services for older adolescents including vocational services and independent living services.
- Additional services in outlying areas.

- Entitlement Programs - Whether appropriate entitlement programs have been received
- Stable Housing - Whether the child has had stable housing (living with the same family or treatment setting) in the community for one year or more
- Community Tenure - Whether the child has had no psychiatric hospitalizations for one year or more
- School Tenure - Whether the child has remained in school for one year or more
- Restrictiveness of Setting - Whether the child has moved into a more or less restrictive setting in school or housing areas
- 508K Submission - Whether the 508K was submitted in the current fiscal year

Another new development in the area of evaluation is a case review process whereby the status of each youngster and family served by the Cluster will be assessed on a regular basis. The review process involves an interview with the child and with the providers to determine progress, the appropriateness and responsiveness of services, and problems that should be addressed at the Cluster level. Members of the ACCORD are responsible for conducting the case review procedure.

XII. MAJOR STRENGTHS AND CHALLENGES

Through interviews with key informants representing a wide variety of constituencies involved in the Stark County system of care, a number of factors that are critical to the success of the system were identified. The major strengths of the Stark County system include the following:

- **Leadership** - One of the principal strengths of the Stark County system lies in its leadership. The involvement and commitment of the executives of the child-serving agencies in the community have provided the impetus and continuing support for system of care development over time. The Cluster has provided a forum for agency executives to remain closely involved in decision making about both system development and individual youngsters. Respondents emphasized that the close direct participation of agency executives in planning and overseeing the system of care has been essential for sustained progress. Thus, the leadership provided by a core group of agency executives, coupled with their long-standing commitment to system of care development, has been crucial to the success of system development efforts in Stark County.

  Respondents noted that the stability of the key players in the Stark County system of care may also contribute to its success. Many of the leaders have served in the Stark County system for many years; they may have served in different capacities and been involved in different aspects of planning and decision making for the system. This "tapestry" of players or recycling of individuals on various task forces, committees, and the like has created a sense of continuity and history in the community. The personal relationships that have developed among these key leaders in the system also have proven to be an asset. Respondents described a group of people who get along well, who interact effectively, and who have developed high levels of trust based upon long-standing working and personal relationships.

- **Shared Responsibility and Vision** - A strength that became apparent during the site visit is the sense of shared responsibility and mission that pervades the Stark County system of care. Respondents from the various agencies expressed a sense of collective ownership of the target population, indicating that participants have succeeded in bridging some turf barriers and in embracing the belief that children and families have multiple needs which cannot be met by individual agencies in isolation. Participants appear to regard the Cluster as "greater than the sum of its parts" and genuinely believe that they will be more effective if they accept joint responsibility for Stark County children and families and work together to build a comprehensive service system.

  Similarly, the philosophy of the system of care in the county appears to be well-ingrained and shared among the various participating agencies. The basic elements of the system philosophy began to be articulated nearly 20 years ago, resulting in a widely accepted vision and goals for the system of care. The concepts of interagency collaboration, serving children within the home and community, and family focus appear to be accepted both by agency executives as well as most providers. This shared responsibility for multineed youngsters and their families and the shared vision and goals for a system of care have provided a firm base for system development.

- **Proactive Attitude** - Respondents emphasized that Stark County has not received a great deal of special or extra funding to support their system development efforts. Nevertheless, the sheer determination to create an effective system of care has enabled the community to proceed without many extra grants or support. The community has been described as "the little engine that could," moving ahead and taking action with few resources and in the face of formidable barriers. Much of the progress in Stark County is attributed to a proactive attitude which moves the system ahead in spite of scarce resources or disappointments such as unsuccessful grant applications. Participants expressed the attitude of doing "whatever it takes" or "just doing it" rather than waiting for grants or other opportunities. The Cluster tends to focus on what is possible rather than on constraints or what is not possible. Thus, an important strength in Stark County is a proactive and positive attitude which emphasizes what can be accomplished and propels the community to take action to address identified problems.

- **Cooperative Approach to Problem Solving** - A cooperative approach among the participating agencies was identified as an important strength in Stark County. As noted, the belief that the various child-serving agencies will be more effective collectively and the joint sense of responsibility for troubled children are evident in the community's efforts. Beyond this, however, is a willingness to confront and resolve problems openly and in good faith. When the inevitable disagreements among agencies arise, participants do not leave the table, but rather are committed to working them out. Further, participants appear committed to working with "reluctant" agencies over time, providing encouragement meaningful opportunities for them to become more involved. Often the retreat process has successfully been used as a forum for discussing and resolving disagreements among system participants.

- **Service Implementation** - The creation and gradual expansion of an array of services within the community is a major strength of the system of care. The CASC established the goal of developing a comprehensive continuum of care early in its history, and over time has built the capacity to provide services including day treatment, intensive home-based services, emergency in-home services, services for sex offenders, case management, and individualized wraparound services. The ability to translate plans into actual service capacity is an essential aspect of system building and is an aspect in which Stark County has realized particular success.

- **Size of Community** - Several respondents postulated that the size of the community may be an asset that has facilitated the community's system building efforts. The community is not so small that it is bereft of services and resources, nor is it so large as to be unmanageable. Rather, Stark County is a moderately sized community which has a respectable array of services and resources and in which human service personnel tend to know one another. Respondents speculated that larger metropolitan areas may face additional challenges in creating multiagency systems of care. The multiplicity of agencies and personnel may result in disorganization and fragmentation. From an organizational standpoint, it may be necessary to break larger metropolitan areas down into more manageable service areas in order to maximize the probability of developing a cohesive, coordinated system of care with effective services and interagency relationships. Thus, the size of Stark County may be a factor that has facilitated system development.

While the Stark County system embodies a number of noteworthy strengths, it also faces a number of challenges which must be overcome in order to ensure continued development of the system of care. These include:

- **Funding** - Most communities report that financing presents the most significant barrier to system of care development. In Stark County, respondents related that, in fact, the lack of adequate funding presents a formidable challenge to the child-serving agencies in their attempt to create a comprehensive community-based system of care. Insufficient funding to create the needed service capacities has slowed progress as have the constraints presented by inflexible, categorical funding streams. Respondents indicated that financing streams have not yet caught up with the changes in philosophy and approach used in state-of-the art community-based systems of care. While the Cluster has used creative approaches to blend funds and fund individualized service plans for children and families, additional funding opportunities and creative solutions will be needed to continue system development. The current fiscal crisis in the State of Ohio may only serve to compound the challenge of locating and creating financing sources for the system of care.

- **Human Resource Needs** - The need for qualified personnel to provide services within the system of care represents another critical challenge for Stark County. Agencies have found it difficult to recruit specialists in children's mental health services, particularly those who are adequately trained, and prepared, to work in nontraditional programs such as home-based services and case management. This is due partially to the limited pool of mental health professionals specializing in children's services as well as to the inadequate training currently provided by most colleges and professional schools.

The community has taken some steps to address human resource needs for the system of care. The Children's Coordinator of the Mental Health Board approached a faculty member in the Center for Family Studies at the University of Akron to discuss the need for trained professional to provide home-based services. Their discussions resulted in the preparation of a grant application for the development of a training program in this area. The grant ultimately was funded by the Ohio Department of Mental Health, and an interdisciplinary training program was developed which provides graduate level training for home-based therapists. Another step taken to address human resource requirements was the design and implementation of a psychology internship program at the CASC. The internship program, which is approved by the American Psychological Association, provides a diverse set of experiences to interns, enabling them to develop expertise in community-based service approaches. The interns augment the staff in the various CASC programs, and some are expected to remain working in the system of care in some capacity following completion of their education. Despite these activities, the need for adequate numbers of trained staff remains a challenge for the Stark County system as well as for other communities seeking to develop systems of care.

- **Educating Line Staff** - The system of care philosophy, though clearly articulated and accepted at higher levels, does not always "trickle down" to line workers. Thus, a continual challenge for the community is to ensure that line workers in all child-serving agencies are well-versed in, and accept, the system of care philosophy and values including the collaborative interagency relationships and approach. Staff turnover at all agencies compels the process of educating line staff to be ongoing and also compels managers to continually model and reinforce the philosophy and collaborative attitudes. Managers emphasize that a system cannot function when a philosophy is accepted only at administrative levels and there is merely hope that it will filter down. Rather, conscious attempts must be made to sell the ideas at all levels of the system until they become ingrained in the system.

  A difficult challenge has been to change the attitudes and approaches of staff trained in more traditional service delivery approaches. For example, outpatient services at the CASC have used an office-based approach, typically relying on weekly 50-minute counseling sessions. In many communities, resistance is encountered when an attempt is made to shift to more intensive and flexible approaches. Educational strategies, coupled with first-hand experience with new approaches, are needed in Stark County for continued change in both attitudes and priorities as the system of care develops.

- **Service Gaps** - Filling service gaps represents yet another challenge for the Stark County system of care. While there has been remarkable progress in developing a service array in the community, respondents agreed that several types of services are sorely needed -- therapeutic foster care, crisis residential services, and services for sex offenders. The Cluster is addressing each of these gaps and attempting to develop both strategies and resources to support the development of these services.

A related, and perhaps more arduous, challenge is to increase the capacity of existing services to more adequately meet the need in Stark County. As noted, wait lists are common at the CASC, and nearly all programs do not have the resources to serve all youngsters who are eligible and in need of services. This has proven to be troubling and frustrating for the participating agencies seeking services for youngsters as well as for the CASC managers and staff. Impending cuts in funding for mental health and other human service funding may further exacerbate this situation, and, given the current economic climate, there is little hope for major expansion in either funding or service capacity. Thus, as the system evolves attention will be needed both to create missing service components as well as to increase the capacity of existing services.

One strategy being implemented to partially address this problem involves offering a brief consultation service during intake. If a family situation appears to be deteriorating, intake staff can provide one to two sessions of face-to-face consultation either in the office or home. The purposes of such consultation include identifying community resources that can be accessed quickly and providing some crisis intervention and support. The consultation is seen as a problem-focused, directive, short-term intervention to offer some specific resources and suggestions to the family and to assist in appropriately prioritizing children and families for the CASC waiting list. No fees are charged to either clients or third parties for this consultation service.

o **Family Support and Advocacy Groups** - Stark County has succeeded in involving parents in the system of care in many ways. Parents are involved in planning and monitoring services for their own children, and parents are participants in planning and policy making at the system level through a variety of advisory entities and activities. A significant gap, however, is the lack of parent support and advocacy groups in the county which focus on children with emotional disturbances. The need for increased opportunities for mutual support among parents as well as the need for parent advocacy is acknowledged. However, little progress has been achieved in this area to date. An important challenge for the future development of the Stark County system is to stimulate and facilitate the development of parent groups which may ultimately fulfill the functions of both parent support and parent advocacy.

o **Involvement of All Agencies** - In creating a coordinated system of care, most communities encounter one or more agencies which are reluctant to participate fully in interagency entities and activities. Care must be taken to ensure that those agencies which appear less committed to the collaborative efforts do not impede progress. In Stark County, as elsewhere, continual efforts are required to involve all child-serving agencies, even those which may be less enthusiastic participants.

One challenge in Stark County is presented by the fact that local school districts have not been closely involved in the Cluster. The Special Education Director of the Canton City Schools has been an active and dedicated Cluster participant and has served as a liaison with the other 16 local school districts in the county. While this approach has been effective, the lack of involvement of the local districts may aggravate some of the relationship problems with the education system. For example, staff noted that it often is difficult to arrange for appropriate educational placements for youngsters with emotional problems and that some local districts resist testing children and paying for special education and supportive services. The more peripheral involvement of these districts provides fewer opportunities to explore and resolve such intersystem issues. While it may not be feasible to have each local district involved in the Cluster, there may be more systematic and creative opportunities to induce closer working relationships with all of the local education agencies.

- **Community Education** - Another challenge for the system of care is to better educate the community about the needs of troubled children and their families and about the work of the Cluster. Respondents indicated that while Stark County is recognized for its progress in creating a system of care, the community knows little about either the progress achieved or the work that remains to be done. Public awareness and education are needed to create a broad base of support for the system of care as well as to generate future financial support for services. Local tax levies remain an important source of financing for several of the child-serving systems, and, therefore, the future of Stark County's system of care may rest squarely in the hands of its citizens.

While these complex challenges remain, Stark County has made substantial and impressive progress toward creating a community-based system of care which includes a broad array of services and mechanisms for interagency coordination at both the system and client levels. Respondents noted that their progress was considerably enhanced through periodic retreats for all participating agencies with an outside facilitator. The retreats have provided agency executives an opportunity to escape from their demanding schedules and from the inevitable daily crises which consume their attention and energy. Retreats have offered blocks of time for planning, problem solving, and reaching agreement on key aspects of the system of care including its vision and goals, operating procedures, and financing strategies. The use of a skilled facilitator has assisted the group in remaining focused on the critical issues and on developing and following through with agreed-upon action steps. Stark County participants asserted that the use of retreats and a facilitator could be highly significant and effective tools in the developmental process of a system of care in any community.

APPENDIX L
Ventura County Mental Health Children and Adolescent Project

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Ventura County
Mental Health
Children and
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Stroul, B. A. (1992). Profiles of local systems of care for children and adolescents with severe emotional disturbances: Ventura County, California. In B. A. Stroul, S. K. Goldman, I. S. Lourie, J. W. Katz-Leavy, & C. Zeigler-Dendy, *Profiles of local systems of care for children and adolescents with severe emotional disturbances* (pp. 1 - 37). Washington, DC: CASSP Technical Assistance Center, Center for Child and Mental Health Policy, Georgetown University Child Development Center.

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PROFILES OF LOCAL SYSTEMS OF CARE

for Children and Adolescents with Severe Emotional Disturbances

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Funded by the National Institute of Mental Health
Child and Adolescent Service System Program (CASSP)

July 1992

Profiles of Local Systems of Care

for Children and Adolescents with Severe Emotional Disturbances

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VENTURA COUNTY, CALIFORNIA

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July 1992

PROFILE OF A SYSTEM OF CARE: VENTURA COUNTY, CALIFORNIA

I. COMMUNITY CONTEXT

Ventura County is a large, rapidly growing county on the southern California coast, between Los Angeles to the southeast and Santa Barbara to the northwest. Ventura County's population of 670,000 has nearly doubled in the last two decades; it is also highly mobile. The county is geographically rural, but most of its population lives in four cities: Ventura and Oxnard (225,000 collectively) on the west end, Simi Valley and Thousand Oaks (230,000 collectively) to the east. The remaining population is scattered in numerous smaller communities and rural areas across the county.

The county's diverse geography encompasses deserts, mountains, and beaches. Large tracts of land are still devoted to agriculture, but extensive new development of commercial centers, industry, and residences encroach on the neighboring fields of lush produce. Tourism has also developed along the coastline, which overlooks the Channel Islands. Further inland, the county is ringed by mountains, the Santa Monica Mountains to the south and the rugged San Raphael Mountains to the north.

Oil and agriculture are the chief economic bases. Ventura County ranks among the highest in oil production in California. It is also a manufacturing area for oil-related tools. The county is a major grower of citrus fruit, vegetables, and flowers as well as a center for raising poultry.

Ventura's population reflects some of California's diversity: 66 percent of the population is Caucasian, 27 percent Latino, 5 percent Asian American, and 2 percent African American. Less than one percent of the population is Native American, although the original inhabitants of the area were the Chumash Indians.

While Ventura's medium household income of $45,612 is high, many of Ventura County's family incomes are at or fall below the poverty level. This is especially true for minority families. Forty percent of Latino families, seven percent of African Americans and five percent of the Asian families meet this poverty standard.

In mental health, as in many other arenas, California has been a leader. It was one of the first states to decentralize public services for people with mental illness when it passed the Short-Doyle Act in 1957, turning over responsibility for mental health services to its 58 counties. Legislation passed in the 1980s (AB 3920, AB 377 and AB 3777) has strengthened the county role in mental health by providing incentives to counties to serve mental health clients in community-based alternatives rather than state hospitals. In California, county governments are strong and exert a high degree of local autonomy over services and decision-making.

In 1992, California initiated a policy called realignment which transfers resources for health, social services, mental health, alcohol and drug abuse from the general state fund to a local trust fund. This funding mechanism will provide counties with a greater degree of budget control and stability. Based on a formula, counties will receive funds generated from vehicle registration fees and from sales tax revenues. These funds can be used as local match for federal funds.

In Ventura, the following public-sector, child-serving agencies and the Ventura County Board of Supervisors are key players in the system of care.

Mental Health: Ventura County Mental Health Department, Division of the Health Care Agency

Child Welfare: Children's Services Department of the Ventura County Public Social Services Agency

Education: Office of Ventura County Superintendent of Schools and the Ventura County Special Education Local Plan Area (SELPA)

Juvenile Justice: Ventura County Corrections Services Agency (CSA)

Health: Department of Public Health, Child Health and Disability Prevention Program

Board of Supervisors: An elected body of five supervisors that develops and implements policy for the county.

The Ventura County Mental Health Department is divided into four sections: children, adults, seniors, and acute care. A 12-member management team, made up of senior administrative support staff and the chiefs of each of these sections, manages the operations of the Department. A mental health advisory board provides policy guidance to the Department.

II. BACKGROUND AND HISTORY OF SYSTEM OF CARE DEVELOPMENT

The history of the Ventura County system of care for children and adolescents who are severely emotionally disturbed has been an interesting process and demonstrates the importance of leadership at the community level, the building of coalitions, the "marketing" and timeliness of an idea, and support at the state level. As is so often the case, it is individuals with vision and strong leadership abilities who have been the catalyst to producing systems change. In Ventura, the combined forces of a member of the local Board of Supervisors, who is a special educator, and a social worker in the Mental Health Department (now the agency's director) provided the vision and brought together the necessary elements and support to achieve major systems change. According to the agency

As will be discussed in greater detail in subsequent sections, Ventura was able to develop a comprehensive system and demonstrate initial findings that supported both treatment effectiveness and cost avoidance. At the end of the demonstration period, the governor signed a bill granting a three-year extension. With strong support from a broad-based coalition, AB 377 (known as the Replication Legislation) was enacted in 1987 to create a permanent structure for the Ventura children's system and to extend the Ventura Planning Model to other counties. In response to a request for proposal, three additional counties were selected to replicate the Ventura County Children's Mental Health Services Demonstration Project: San Mateo, Santa Cruz, and Riverside. In 1988, legislation was passed (AB 3777) to expand the Ventura model to serving adults.

At the state level, the legislation creating the local Ventura County system of care also requires the state Department of Mental Health to establish an advisory committee comprised of representatives from the state Departments of Education, Social Services, Mental Health, and the Youth Authority; representatives from the Conference of Local Mental Health Directors, California Council on Mental Health, County Welfare Directors Association, Chief Probation Officers Association, School Administrators Association; and a representative of the service providers from the private sectors. The function of the group is to advise and assist the state in the development of a coordinated, comprehensive service system of care.

III. PHILOSOPHY AND GOALS

The philosophical underpinnings for the Ventura Planning Model, determined in the initial developmental phase, were built into the enabling legislation and remain in statute. In the discussions that occurred between service providers, agency heads, and the community's political leadership, certain points of agreement and principles emerged. These tenets are: 1) that it is in the public's best interest to enable a high risk child to remain in his or her home or to be treated in the local community, and 2) that if a child must be removed from the home, local treatment prevents costly and restrictive residential and hospital placement. The premise on which the Ventura model is based is that a community-based, interagency system of mental health care which targets the most disturbed children will provide the greatest benefit to children, their families, and the community at the lowest cost to the public sector. By legislative statute, the Ventura County Demonstration Project was to demonstrate "cost avoidance" through the development of alternative in-county services.

The five essential elements of the Ventura Planning Model derive from this foundation. They are also considered to be generic principles, rather than specific program examples or models, that are applicable to other communities organizing systems of care. The elements also respond to the legislative mandate that Ventura establish a system that can be replicated in other sites. These elements, specifically delineated in the legislation, include:

- A clearly defined set of targeted populations that include those youth who are at greatest risk of out-of-home placement and for whom the public sector already has legal and fiscal responsibility;

- Measurable goals that are committed to the preservation of family unity and locally-based treatment;

- The development of viable partnerships at the policy, planning, and service level between public sector agencies, between the public and private sectors, and between agencies and families;

- The development of collaborative program services and standards that adhere to the service philosophy of family preservation, family reunification, and least restrictive environment -- developing service plans tailored to an individual child and family and having available a continuum of service options and settings that cross agency boundaries;

- The development of a mechanism and process for system evaluation that measures client outcome and costs over time and across programs and ensures system accountability.

Client outcome objectives for the Ventura Planning Model are to enable youth who are severely emotionally disturbed to remain or be reunified with their families, to attend and progress in public schools, and to not commit crimes. Program development and evaluation are geared to the achievement of these primary objectives.

IV. TARGETED POPULATIONS

Determining the targeted populations for Ventura's system of care has been critical to the success of the program, but the very nature of defining a target population and narrowing the scope of those to be served creates controversy as well. As noted, definition of the population is one of five essential elements of the Ventura model. There are a number of important reasons for identifying the population to be served. These are to ensure public agency accountability, to achieve multiagency support, to focus limited public dollars on those most in need, and to enable program development to be appropriately tailored to the population to be served.

One of the first concerns was developing a definition that would be acceptable to the multiple agencies essential to the system -- Child Welfare, Education, Juvenile Justice, and Mental Health. The first three agencies all have mandates specifying the populations that they have a responsibility to serve. Since Mental Health does not have a similar mandate, these other agencies wanted to ensure that the population targeted for the service system would include the youth these agencies are required to serve. The consensus was that the priority populations to be served by Ventura's system would include the following:

- Those emotionally/behaviorally disordered court dependents whose histories include neglect, physical and/or sexual abuse, multiple foster home placements, residential treatment, and psychiatric hospitalization;
- Those emotionally/behaviorally disordered court wards for whom the public sector has legal responsibility as a result of delinquent behavior and consequent court order who are at risk of out-of-home placement, i.e., residential placement, psychiatric hospitalization, and/or incarceration;
- Those emotionally/behaviorally disordered special education pupils who require mental health services in order to benefit from their Individual Education Plan (IEP); and
- Those emotionally/behaviorally disordered children who are not part of a formal agency other than Mental Health and are at risk of out-of-home placement into state hospitals or residential treatment.

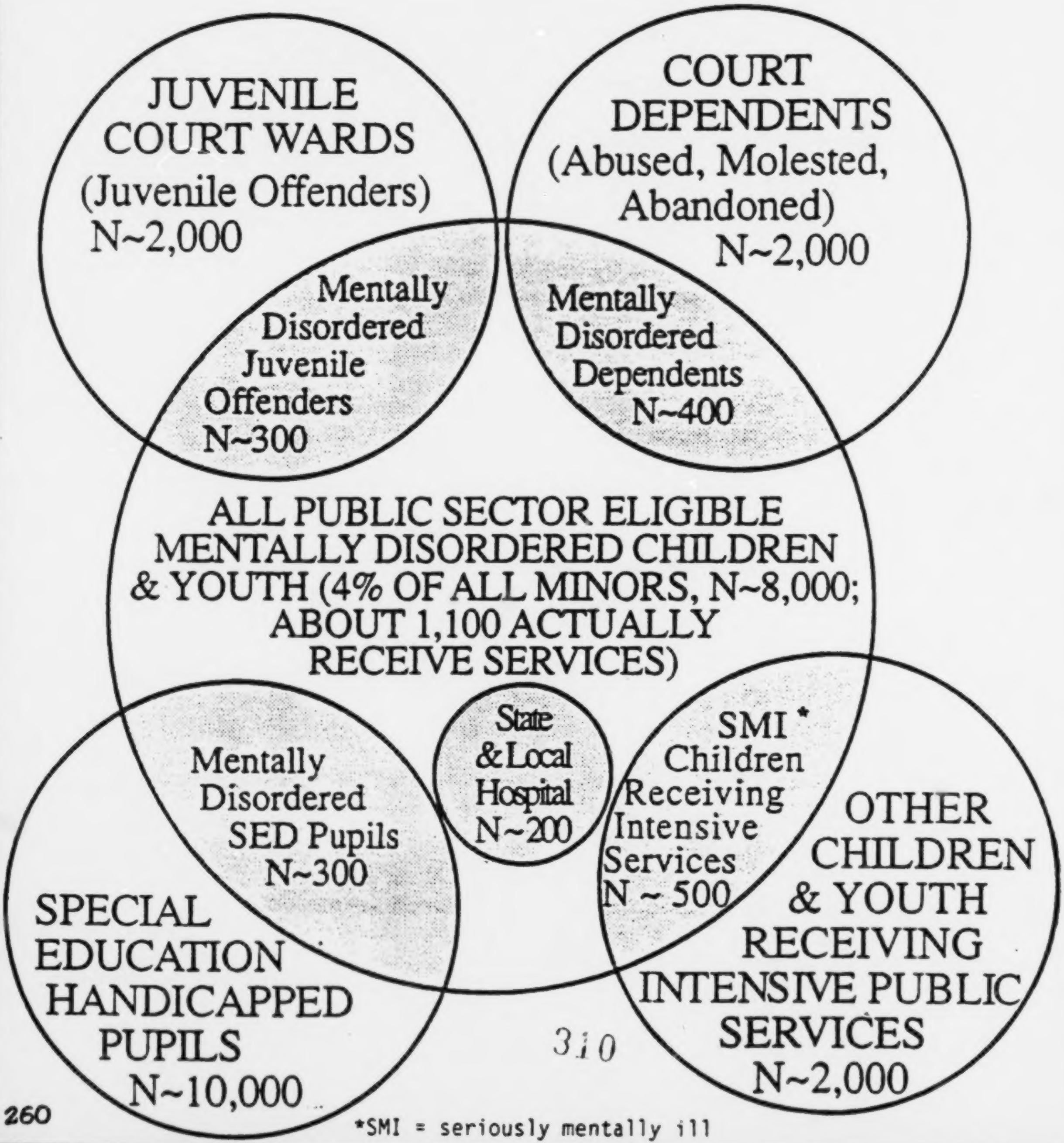
The diagram on the next page depicts those groups targeted in the Ventura model. The system's target populations are those in the shaded areas. Each of these target groups includes those at risk of entering that group. The numbers are projections based on the actual annual treatment caseloads for each group in Ventura County. Of the 1,700 youth designated as the target population at risk, 670 are served in the system at any point in time. A total of 1,400 receive services each year. Less than one percent of the children under 18 in Ventura County are included in the target population.

While it is often desirable for policy makers to target groups for fiscal reasons, it becomes difficult for clinicians to use those broad classifications in determining who of the many needy children they see should be given priority in receiving service. Thus, since the establishment of its initial definition of the target population, a special task force struggled for over two years to define specific target population criteria that can be used in daily practice. Descriptions of the target populations and criteria for including youth are shown on pages 10 and 11. The Mental Health Department has adopted the criteria and redirected all program staff and resources to serve this population of severely disturbed and high-risk clients. Ventura has also implemented a target review process and progressively discharged all nontarget clients, subject to clinical review for appropriateness. A survey of current clients indicates that more than 95 percent currently meet the target population criteria.

This narrowing of the population to be served by the Mental Health Department has raised concerns by some sectors about the elimination of early intervention activities that could prevent youth who are at lower risk from becoming more severely disturbed. If services are not available to youth at earlier, critical junctures, critics argue, their situation may become worse, increasing the likelihood that they will become members of the target population. While

THE CHILDREN & YOUTH TARGET GROUPS IN THE VENTURA MODEL

(Less than 1% of Ventura County Children under 18 are included in the Target Population)


JUVENILE COURT WARDS (Juvenile Offenders) N~2,000
COURT DEPENDENTS (Abused, Molested, Abandoned) N~2,000
Mentally Disordered Juvenile Offenders N~300
Mentally Disordered Dependents N~400
ALL PUBLIC SECTOR ELIGIBLE MENTALLY DISORDERED CHILDREN & YOUTH (4% OF ALL MINORS, N~8,000; ABOUT 1,100 ACTUALLY RECEIVE SERVICES)
State & Local Hospital N~200
Mentally Disordered SED Pupils N~300
SMI* Children Receiving Intensive Services N ~ 500
SPECIAL EDUCATION HANDICAPPED PUPILS N~10,000
OTHER CHILDREN & YOUTH RECEIVING INTENSIVE PUBLIC SERVICES N~2,000

*SMI = seriously mentally ill

WHO WILL RECEIVE PRIORITY -THREE FACTORS

1. Risk

Children at greatest risk with a mental disorder should receive priority for limited tax supported local mental health services.

A Governor and Legislators concerned about the future have an interest in redirecting the lives of children at greatest risk of becoming dysfunctional adults. Studies of today's incarcerated, homeless, chronically unemployed, and institutionalized adults reveal childhood and school histories of severe family conflict and breakdown, physical and sexual abuse, delinquent behavior, and school failure and dropout. In these histories parents and teachers report unpredictable, impulsive, aggressive or destructive behavior, or depressed, withdrawn, isolated, and strange behaviors. These patterns are frequently manifestations of severe childhood mental disorders though few of these dysfunctional adults received any appropriate mental health treatment as children.

Early and premature separation from the family is a critical and usually irreversible event in their lives as children. Bouncing between divorced parents, multiple foster home placements, residential treatment placements, psychiatric hospitals, state hospitals, and incarceration in juvenile justice facilities were frequently part of the downward whirlpool cycle for these adults. Separation from family both reflects clinical severity and adds risk to the tenuous and damaged child's hope for the future. Even necessary separation adds risks for these children's chances to regain a place in their family, school and community.

2. Legal Responsibility

Mentally disordered children with existing public agency legal responsibility should receive priority for limited tax supported local mental health services.

When government by the action of a Superior Court Judge or other Court Officer for protection or due to delinquent behavior takes legal and/or physical custody of a child from a parent,it assumes an awesome and heavy legal responsibility for that child. When a court ward or dependent has an identified mental disorder the Judge has a legal responsibility and obligation to provide appropriate mental health assessment and treatment.

Under Federal Law PL-94-142, handicapped students have a right to receive an appropriate education at no cost to their parents. As part of an appropriate education special education pupils are guaranteed mental health services "related" to their education as part of their individualized education plan. This law clearly establishes a legal responsibility and obligation to provide mental health services in these instances.

3. Fiscal Liability

Mentally disordered children who for lack of appropriate mental health services pose the greatest financial liability to the public should receive priority for the limited tax supported local mental health services.

Public agency programs, including Special Education, Child Protective Services, Juvenile Justice and Mental Health provide a continuum of services in graduated levels of restrictiveness and cost. Untreated, seriously emotionally disturbed children fail at less restrictive levels of service and "graduate" to more restrictive and expensive levels. Foster home failures, special education class changes and failure, and probation violations, lead eventually to residential treatment placements, local and state hospital admissions, or incarceration. Tax supported residential placements range from $25,000 to $75,000 per year, Medicaid and State psychiatric hospitals from $100,000 to $200,000 per year and incarceration about $25,000 per year.

A system of less expensive local mental health services targeted to children separated or at imminent risk of separation with the goal of family maintenance or reunification can offset a major portion of the cost by reducing the number of children and length of stay in 24-hour facilities.

Ventura Planning Model Target Populations

MENTALLY DISORDERED CHILDREN & YOUTH

Must Have (I, II & III) *OR* (I, II & IV) *OR* V:

I. Diagnosis

DSM III-R Axis I or II diagnosis, except a primary diagnosis of Psychoactive Substance Use Disorder, Developmental Disorder, or V Code. Organic Mental Disorders are included only while behaviors are a danger to self or others.

II. Risk of or Separation from Family

Risk of or separated from family due to, for example: (1) Chronic family dysfunction involving a mentally ill and/or inadequate caretaker, or multiple agency contacts, or changes in custodial adult; or (2) going to, residing in, returning from any out-of-home placement, e.g., psychiatric hospital, short-term inpatient, residential treatment, group or foster home, corrections facility, etc.

III. Functional Impairments/Symptoms

Must Have A *OR* B:

A. **Functional Impairment.** Must have substantial impairment in two of the following capacities to function (corresponding to expected developmental level):
   1. **Autonomous Functioning.**
   2. **Functioning in the Community.**
   3. **Functioning in the Family or Family Equivalent.**
   4. **Functioning in School/Work.**

B. **Symptoms.** Must have one of the following:
   1. **Psychotic Symptoms.**
   2. **Suicidal Risk.**
   3. **Violence:** At risk for causing injury to person or significant damage to property, due to a mental illness.

IV. History

Without treatment there is imminent risk of decompensation to Risk of or Separation from Family in Section III, above.

V. Special Education Eligible Under Chapter 26.5 of the California Education Code (AB 3632).

All Ages: Victims of an officially declared natural disaster or severe local emergency.

Draft Revised March 13, 1992

agreeing that this is a problem, Department leadership believes that since public resources are not sufficient to serve everyone, resources must be targeted to those most in need. The definition and criteria developed are intended to guide that decision-making and triaging process. The rationale is that fewer people will be served better. This strategy also can be applied successfully to developing systems of services for other populations. Targeting the high end of the spectrum in cost and utilization may also provide justification for additional resources to support prevention and early intervention activities.

V. ORGANIZATION OF THE SYSTEM

System Management

Ventura County has taken a unique approach to developing a system of care. The key to understanding the Ventura system is understanding the role the Mental Health Department plays and its position vis a vis the other child-serving agencies. The basic concept is that mental health services are integrated into the service systems of the major child-serving public agencies -- Juvenile Justice, Special Education, and Child Welfare. Mental health services go to where the child is. This has not only proven to be better for children and families, but also has created a change in how each of the agencies carries out its work. Agencies now function differently even when Mental Health is not directly involved with a child.

The architects of the Ventura model believed that a service system for youth must involve all the major child-serving agencies and must provide an array of services that will enable youth, when appropriate, to remain in the county and in their homes. At the same time, there was the recognition that the state has legal mandates for different youth, and the agencies charged to carry out these mandates are often limited by specific eligibility criteria, laws and regulations dictating their responsibility to the target population. Across the country, these mandates, while a protection to youth, have also served as barriers to developing more integrated, comprehensive service systems. The Ventura approach deals with the realities of different agency mandates and eligibility policies.

In the Demonstration Project (AB 3920), the Mental Health Department uses its fiscal and staff resources to provide the service components that would enable youth to be served in the county in the least restrictive setting. By integrating mental health services into each system, there is less need to refer a youth to a state hospital or residential treatment center to obtain needed mental health services. The "intensity" of the service provided in the community can serve as an alternative to more restrictive placements. In Ventura, the method of interagency integration varies by service system. Roles and relationships are delineated in interagency agreements. Mental Health serves as the system's core and provides specialized services to each system -- Juvenile Justice, Child Welfare, and Special Education. These services are described in more detail below.

In addition to interagency agreements which spell out joint administrative, fiscal, and service responsibilities, the Ventura County system of care is linked through several *key interagency coordinating* mechanisms as shown in the diagram on the next page. The Interagency Juvenile Justice Council is a policymaking body made up of all the public agency directors and the judges. The chair of the Council is the presiding judge of the Juvenile Court. The Interagency Case Management Council is the vehicle for case resolution and the identification of service system gaps and problems. The Case Management Council consists of agency representatives who have the authority to commit resources for each public service agency.

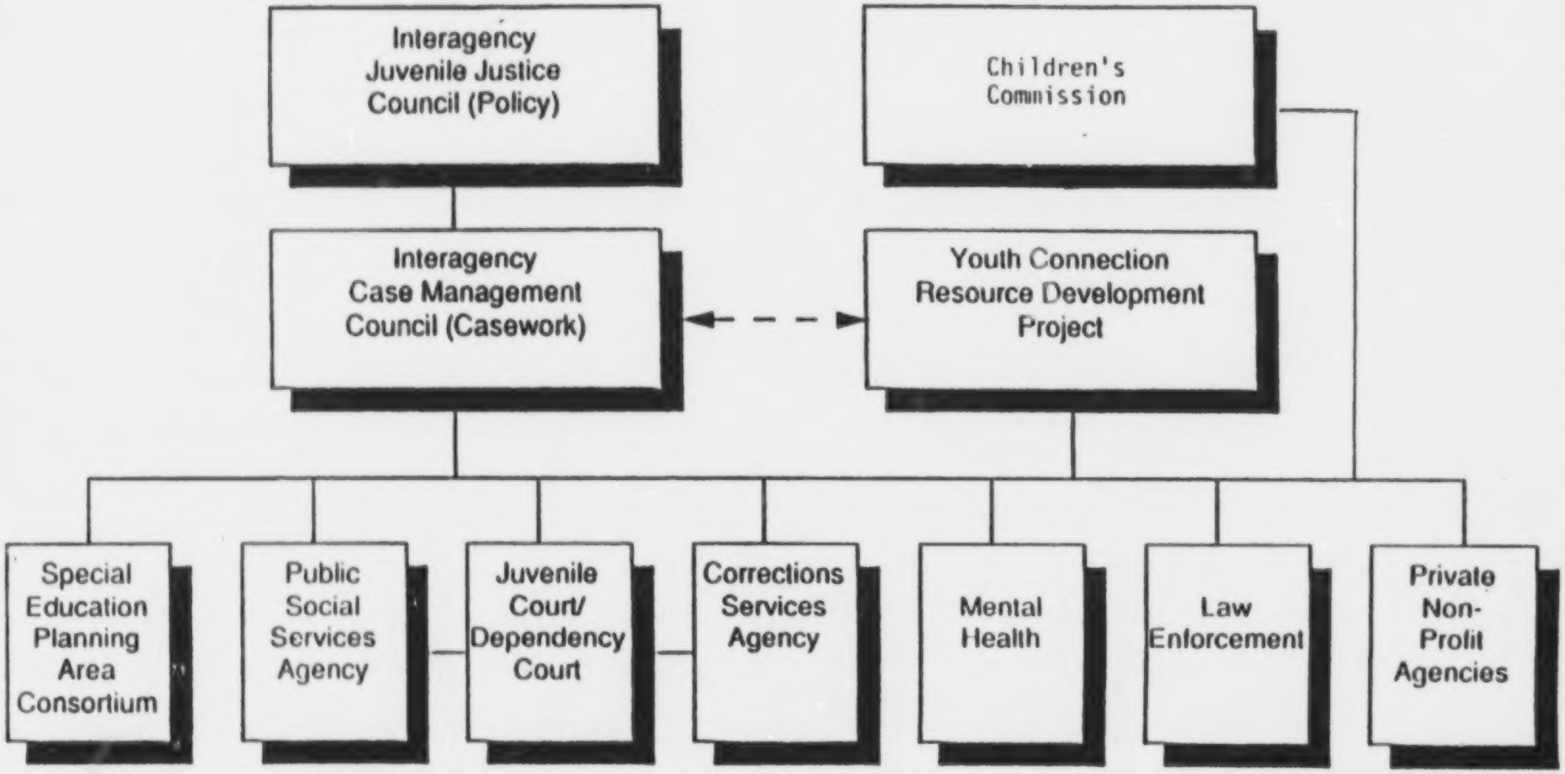
Role of Participating Agencies

o Mental Health: Ventura County Mental Health Department, a Division of the Health Care Agency

As indicated in the section on the developmental background of Ventura's system, the Mental Health Department has undergone some significant changes in the decade of the 1980s. Initially the Department was organized under a director and reporting to him were three regional managers. There was also a separate children's division that included nine outpatient therapists. The Demonstration Project, when it was started, was a separate initiative with its own budget, staff, and project director who reported to the Director of Mental Health. As the Demonstration Project evolved, it took on a life of its own and in some ways overwhelmed the Department. In 1987, the project's status as a "demonstration" ceased. Since that time several major reorganizational changes have occurred within the Department. The former director of the Demonstration Project is now the Director of Mental Health for the county. The staff and programs of the previous Demonstration Project are fully integrated into the Department, and the outpatient children's services are converting their mission to serving the target population. One of four sections within the Mental Health Department is now devoted to children. The Children's Section includes a Chief of Children's Services and supervisors for Case Management, Special Education, Child Protective Services, Juvenile Justice, and Outpatient Services. Staff also include a medical director and research psychologist.

The Mental Health Department served as a catalyst in the development of the system of care and works in concert with the other child-serving agencies. As indicated above, roles and responsibilities are delineated in interagency agreements. Interagency mechanisms exist for planning purposes and for problem resolution. However, to understand how the system functions as a whole, it is useful to examine how Mental Health relates to and works with each agency individually. It is also important to contrast the situation before and after the Demonstration Project. These relationships are explicated in the discussions of each of the key participant agencies in the system of care.

Ventura County Interagency Network



Interagency Juvenile Justice Council (Policy)

Children's Commission

Interagency Case Management Council (Casework)

Youth Connection Resource Development Project

Special Education Planning Area Consortium

Public Social Services Agency

Juvenile Court/ Dependency Court

Corrections Services Agency

Mental Health

Law Enforcement

Private Non-Profit Agencies

In the Ventura system of care, mental health staff work in settings within Education, Child Welfare, and Juvenile Justice. The Mental Health Department provides an intensive outpatient service and a clinically-oriented case management unit that serves as a "broker" to the system. Mental health staff serve as a liaison to each of the three major systems and supervise the mental health clinical staff working in that setting.

o Juvenile Justice: Ventura County Corrections Services Agency (CSA)

In Ventura County there are two full-time judges for youth, dealing respectively with delinquency cases and dependency cases. By county policy, judges normally rotate every two years. The Corrections Services Agency (CSA) operates the existing programs for youth within the juvenile justice system. A number of these programs are conducted through the interagency efforts of Mental Health and the Ventura County Superintendent of Schools. The three local institutions consist of the Clifton Tatum Center, which is the Juvenile Hall, an 84-bed maximum security setting for pre-and post-dispositional minors; the Colston Youth Center, a 45-bed medium security residential facility; and the Juvenile Work Release Program, a 24-bed minimum security facility. Wards of the court are also sometimes ordered into "Suitable Placement" which encompasses the following: residential treatment centers (out-of-county), group homes (in-and out-of-county), small family homes (in-county), and foster homes (in-county). The funding for all of the "Suitable Placement" services is through Aid to Families with Dependent Children (AFDC). Wards of the court may also be ordered home on probation and assigned to deputy probation officers located in three main field service sites in the county.

Approximately 2,000 youth go through the juvenile justice system annually, with CSA providing an array of services ranging in restrictiveness from delinquency prevention and youth services, informal probation, formal probation, removal of youth from their homes to commitments for a small percentage of youth to the California Youth Authority. Although mental health services might be appropriate for a vast majority of these youths, resources have been concentrated to serve the highest risk youth, those who have the most serious delinquency histories and also the most serious mental health problems. The cornerstone of the Demonstration Project, and still the largest program in the juvenile justice system, is the Colston Youth Center. Youth are committed there for four- to six-month periods. The program is operated on an interagency basis with CSA, Mental Health, and the Superintendent of Schools. Mental health services are also provided at the Clifton Tatum Center, but these are limited to suicide risk assessment, crisis intervention, and brief therapeutic interactions. The limited mental health resources in the county have been designed to be placed in treatment settings where the highest impact is likely to be felt.

Since the Demonstration Project, there have been several new additions to the services within the juvenile justice system. One of these is the Visions Interagency Program (VIP), a three-day-a-week day treatment school serving wards and dependents of the court. This is also operated on an interagency basis with CSA, Mental Health, the Superintendent of Schools, and Children's Protective Services. In addition, the Forensic Adolescent Program (FAP) provides long-term (approximately 18 months) outpatient services to juvenile sex offenders. The youth might be committed for some amount of time to the Colston Youth Center, a local group home setting, or home on probation in order to receive the individual, group, and family therapy services provided by FAP. The FAP mental health staff also provide evaluations to the court regarding the amenability of youth to juvenile sex offender treatment.

Currently there is one mental health supervisor for the juvenile justice system, five full-time equivalent (FTE) mental health staff at Colston, one FTE providing aftercare services to Colston residents, approximately one FTE providing services at Clifton Tatum Center, two FTEs at VIP, two FTEs at FAP and three case managers. The system of care for mentally disordered juvenile offenders is outlined in the diagram on the next page with bullet points designating the mental health services provided.

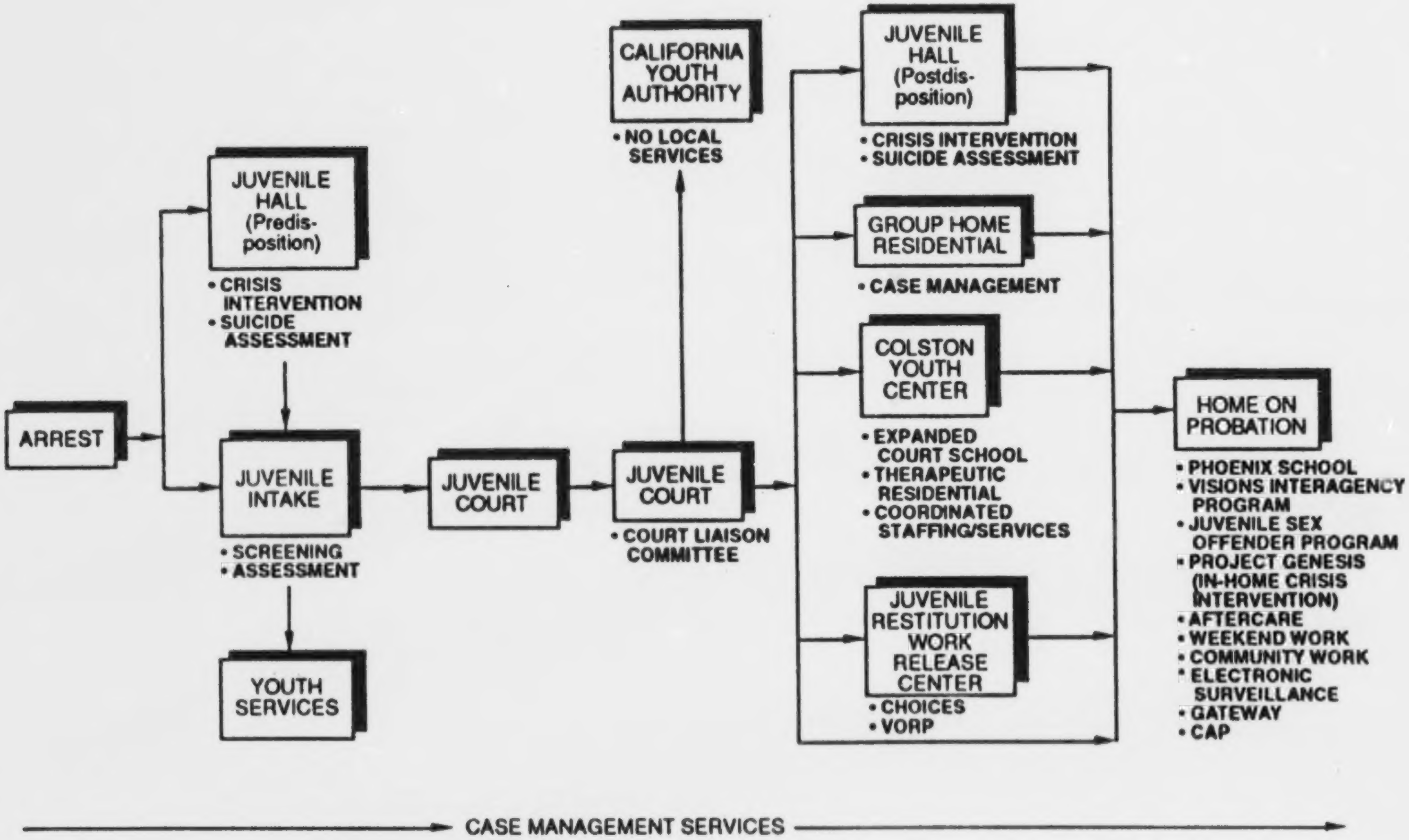
o Child Welfare: Children's Service Department of Ventura County Public Social Services Agency

Mental Health plays multiple roles in the child welfare/protective service system as shown on the diagram on page 18. The "Shomair" team is the centerpiece for the mental health component within the child welfare system. Shomair is the Hebrew word for guardian, meaning one who protects and watches over others.

Shomair staff provide major services to children and youth who have been physically or sexually abused, neglected or abandoned, and who have been removed or are at risk of removal from their homes by the court. The Shomair team interfaces with three different facets of the Child Welfare Division; Children's Protective Services (CPS) staff, foster families, and the children placed in foster care or temporary shelter care. Shomair staff consist of six mental health professionals, all of whom have developed great expertise in the child welfare system. The mental health staff have an office at CPS, are highly visible and available to child welfare staff, and are fully integrated into the child dependency process. Specifically, the Shomair team is involved in assessment and treatment planning, in the enriched foster care program, in collaborative foster parent recruitment and training programs, and in the placement screening committee process.

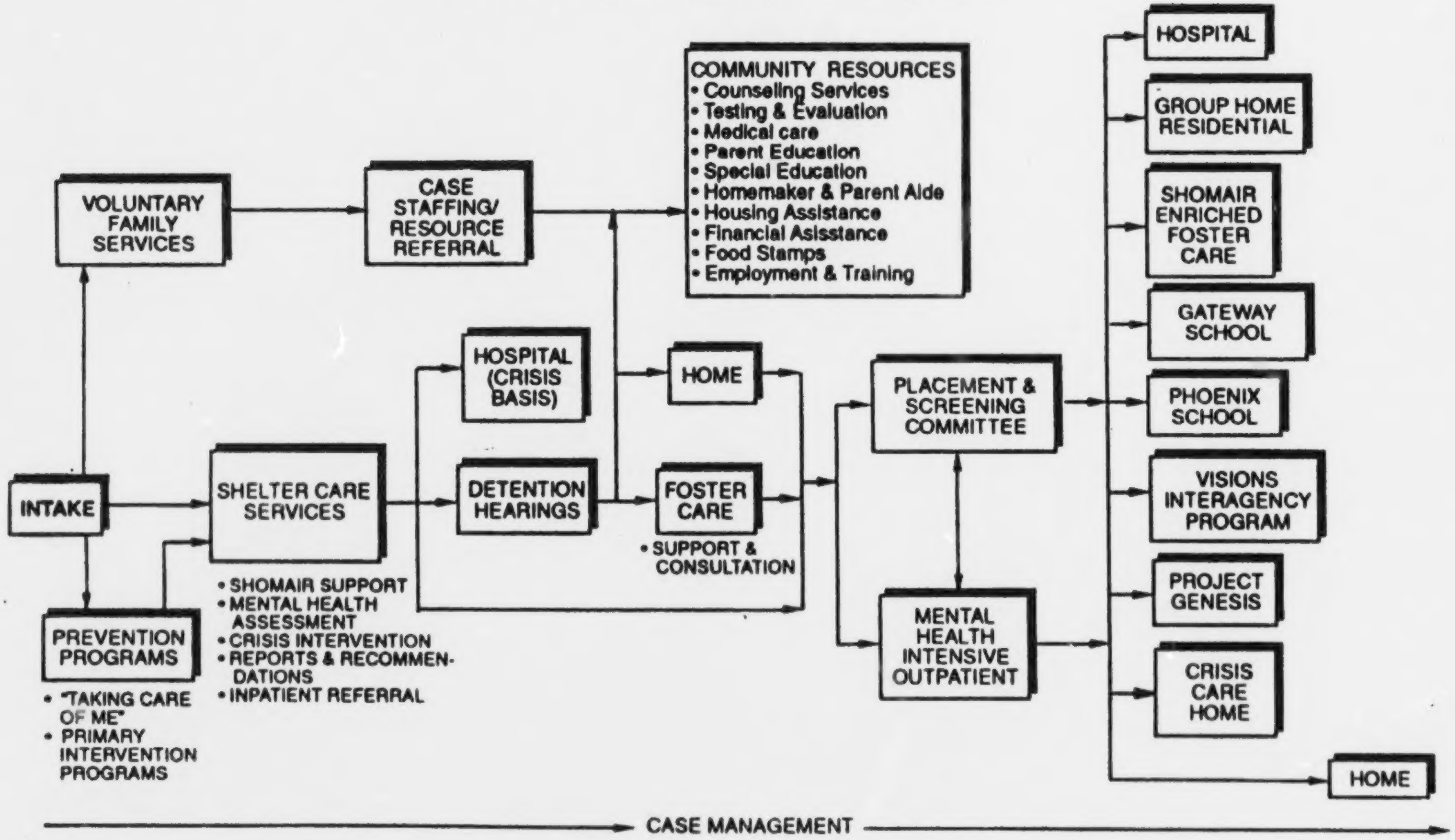
All children entering shelter care (temporary foster protective custody) are assessed by the Shomair staff within 72 hours. In Ventura about 35 youths per month come into shelter care. Assessment includes evaluation of the

Juvenile Corrections Sub-System


ARREST
JUVENILE HALL (Predis-position)
• CRISIS INTERVENTION
• SUICIDE ASSESSMENT
JUVENILE INTAKE
• SCREENING
• ASSESSMENT
YOUTH SERVICES
JUVENILE COURT
JUVENILE COURT
• COURT LIAISON COMMITTEE
CALIFORNIA YOUTH AUTHORITY
• NO LOCAL SERVICES
JUVENILE HALL (Postdis-position)
• CRISIS INTERVENTION
• SUICIDE ASSESSMENT
GROUP HOME RESIDENTIAL
• CASE MANAGEMENT
COLSTON YOUTH CENTER
• EXPANDED COURT SCHOOL
• THERAPEUTIC RESIDENTIAL
• COORDINATED STAFFING/SERVICES
JUVENILE RESTITUTION WORK RELEASE CENTER
• CHOICES
• VORP
HOME ON PROBATION
• PHOENIX SCHOOL
• VISIONS INTERAGENCY PROGRAM
• JUVENILE SEX OFFENDER PROGRAM
• PROJECT GENESIS (IN-HOME CRISIS INTERVENTION)
• AFTERCARE
• WEEKEND WORK
• COMMUNITY WORK
• ELECTRONIC SURVEILLANCE
• GATEWAY
• CAP
CASE MANAGEMENT SERVICES

Flow charts developed by Dr Daniel Jordan, Systems Evaluation, Ventura County Mental Health.

Child Protective Services Sub-System


INTAKE
VOLUNTARY FAMILY SERVICES
CASE STAFFING/ RESOURCE REFERRAL
COMMUNITY RESOURCES
• Counseling Services
• Testing & Evaluation
• Medical care
• Parent Education
• Special Education
• Homemaker & Parent Aide
• Housing Assistance
• Financial Asisstance
• Food Stamps
• Employment & Training
PREVENTION PROGRAMS
• "TAKING CARE OF ME"
• PRIMARY INTERVENTION PROGRAMS
SHELTER CARE SERVICES
• SHOMAIR SUPPORT
• MENTAL HEALTH ASSESSMENT
• CRISIS INTERVENTION
• REPORTS & RECOMMENDATIONS
• INPATIENT REFERRAL
HOSPITAL (CRISIS BASIS)
DETENTION HEARINGS
HOME
FOSTER CARE
• SUPPORT & CONSULTATION
PLACEMENT & SCREENING COMMITTEE
MENTAL HEALTH INTENSIVE OUTPATIENT
HOSPITAL
GROUP HOME RESIDENTIAL
SHOMAIR ENRICHED FOSTER CARE
GATEWAY SCHOOL
PHOENIX SCHOOL
VISIONS INTERAGENCY PROGRAM
PROJECT GENESIS
CRISIS CARE HOME
HOME
CASE MANAGEMENT

Flow charts developed by Dr Daniel Jordan, Systems Evaluation, Ventura County Mental Health.

child for suicidality and depression, identification of placement and treatment needs, crisis intervention, and provision of consultation and recommendations to the shelter parents. This information is provided to the CPS court worker prior to the initial dependency and jurisdictional court hearings.

The Shomair staff provide intensive services to about 28 children in enriched foster care. The Shomair therapist becomes the therapist/case manager for the child and for the entire foster family. Mental health staff coordinate their efforts with the CPS social worker, the biological family, and school and day-care staff. They also provide follow-up care for six months after the child returns home. One Shomair staff person is dedicated to working collaboratively with CPS personnel in the recruitment of foster parents. Specialized training and support groups for foster parents within the Shomair program are offered by this individual.

In addition, mental health and child welfare staff share responsibilities in decision making in a weekly placement/screening committee. This committee, which is comprised of Shomair staff, senior CPS staff, and other appropriate agency personnel, reviews all requests for changes to a more intensive placement (e.g. to enriched foster care, a group home, residential treatment, or hospitalization). A unique placement and treatment plan is developed for each child presented to the committee. Most children returning to less restrictive care are also presented to the committee for suitability and appropriate treatment/living plans when the child reenters the community.

- Education: Office of Ventura County Superintendent of Schools and the Ventura County Special Education Local Plan Area (SELPA)

Ventura County has 20 local school districts and one county school district for special populations. Each school district has its own superintendent, special education unit, and school board; the 21 superintendents from these school districts form a policy-making board. Each region has a coordinator for special education services who reports to this board through a special education coordinating body. All the special education units are coordinated under the Special Education Local Plan Area (SELPA). There are a total of 117,000 pupils in Ventura County, and 12,000 are in special education. According to school standards, 293 of these students are designated seriously emotionally disturbed, but according to mental health staff, the number who are seriously emotionally disturbed more closely approximates 500 based upon 1986 estimates.

California has a unique piece of legislation, AB 3632 (Chapter 26.5), that addresses the problem of mental health versus educational and local services' fiscal responsibility for special education students who require mental health services as part of their Individualized Education Plan (IEP) or out-of-home placement. According to this legislation, students identified as requiring special education are also entitled to appropriate mental health services, if necessary for the student to benefit from the IEP. This legislation requires that local mental health agencies provide case management for children who receive residential services.

Since the Demonstration Project, the relationship between Mental Health and Special Education has changed, and, as with other key child-serving systems, Mental Health now plays a critical collaborative role. Before the Demonstration Project, therapists in the mental health system did not know how many or which youth served in outpatient services were designated as special education students. Now Mental Health is fully integrated into the special education process. Entry into the mental health/special education system, outlined in the diagram on the following page, requires assessment by both agencies. The mental health professional who conducts the assessment becomes part of the student's IEP planning team. Through the Demonstration Project, a number of service options -- from least restrictive first choice service options to more restrictive second choices -- have been developed combining staff and funds of Mental Health and Special Education. Under the first choice, local alternative programs, youth can remain in their local schools receiving supportive mental health services that are part of the Ventura system (such as outpatient, intensive outpatient, and in-home services) in conjunction with special education programs (such as day classes and resource specialists). Two local day treatment programs for high school and elementary students (the Phoenix School and Elementary Program) have been established and are costaffed by Mental Health and Special Education. Enhanced special day classes on regular school campuses have also been established and are staffed by both mental health professionals and special education teachers. Only those students who have exhausted all local, less restrictive options are referred to residential programs. These youth are placed by the mental health case manager who works through the IEP process with the school district and family.

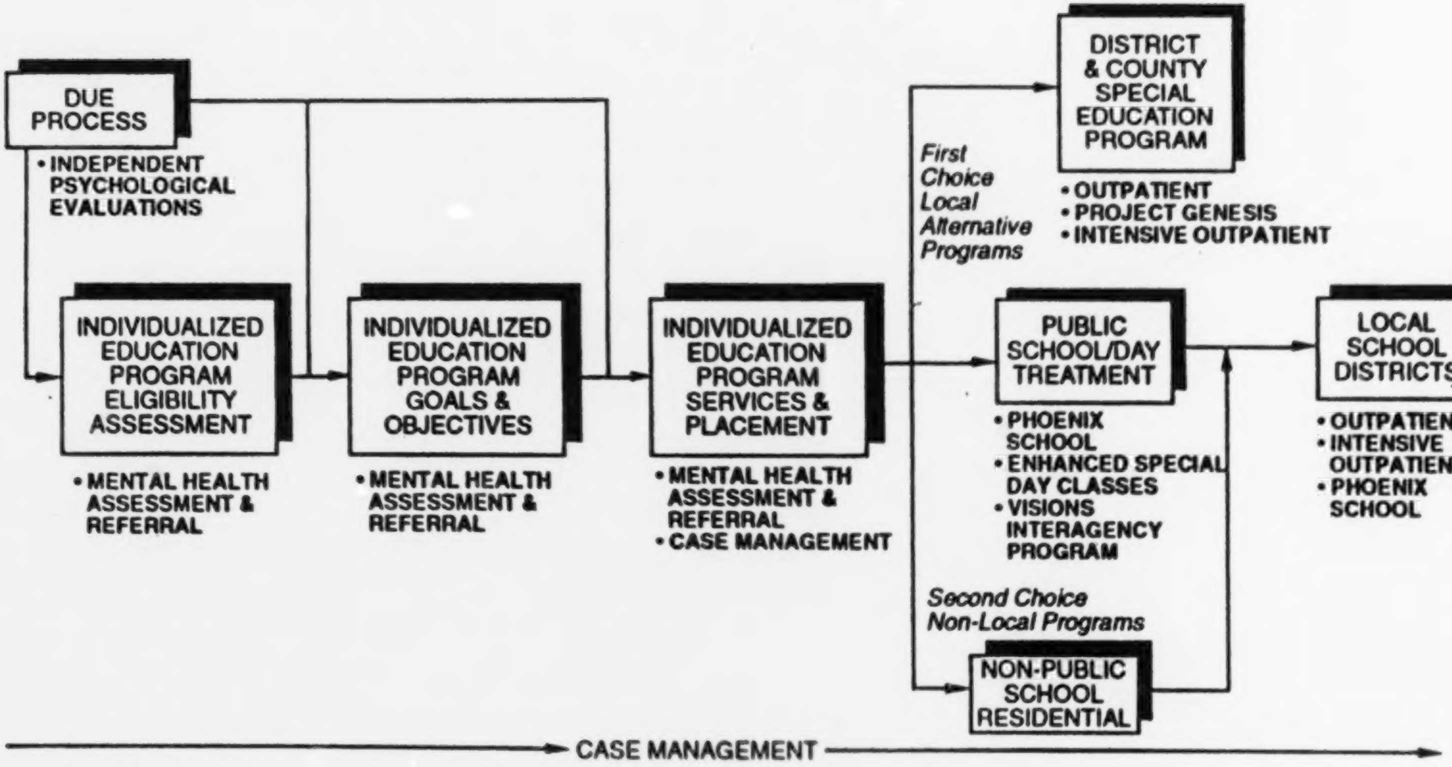
On an administrative level, mental health management staff work cooperatively with special education managers and attend SELPA meetings (comprised of all special education directors) for information exchange, education, problem resolution, and service planning.

- Private Sector

One of the essential elements of the Ventura County system is interagency collaboration between the public and private sectors. This collaboration is accomplished through a number of private/public sector boards, the recently established countywide Children's Commission, the Resource Development Project, and service contracts with private nonprofit agencies, particularly Interface, a private not-for-profit umbrella agency offering multiple child-serving programs.

One of the unique components of the Ventura Planning Model is the Resource Development Project, which operates a bank of goods and

Special Education Sub-System


DUE PROCESS
• INDEPENDENT PSYCHOLOGICAL EVALUATIONS
INDIVIDUALIZED EDUCATION PROGRAM ELIGIBILITY ASSESSMENT
• MENTAL HEALTH ASSESSMENT & REFERRAL
INDIVIDUALIZED EDUCATION PROGRAM GOALS & OBJECTIVES
• MENTAL HEALTH ASSESSMENT & REFERRAL
INDIVIDUALIZED EDUCATION PROGRAM SERVICES & PLACEMENT
• MENTAL HEALTH ASSESSMENT & REFERRAL
• CASE MANAGEMENT
First Choice Local Alternative Programs
DISTRICT & COUNTY SPECIAL EDUCATION PROGRAM
• OUTPATIENT
• PROJECT GENESIS
• INTENSIVE OUTPATIENT
PUBLIC SCHOOL/DAY TREATMENT
• PHOENIX SCHOOL
• ENHANCED SPECIAL DAY CLASSES
• VISIONS INTERAGENCY PROGRAM
Second Choice Non-Local Programs
NON-PUBLIC SCHOOL RESIDENTIAL
LOCAL SCHOOL DISTRICTS
• OUTPATIENT
• INTENSIVE OUTPATIENT
• PHOENIX SCHOOL
CASE MANAGEMENT

Flow charts developed by Dr Daniel Jordan, Systems Evaluation, Ventura County Mental Health.

services donated to assist youth. Services include private counseling, psychological evaluations, dental services, dance lessons, and tutoring. Goods include clothing, recreational equipment, and school supplies. Their value is worth approximately $1 million. The Resource Development Project is operated and staffed by Interface, with initial start-up costs to get the project underway supported by the United Way. A resource list of available goods and services is sent to agencies monthly. Agencies, in turn, make requests for specific youth through a standardized intake form, and a match is made. More than 400 children have been served to date through this exchange.

VI. SYSTEM OF CARE COMPONENTS

Through the various targeted populations and resultant interagency partnerships, Ventura County Mental Health's "system of care" is organized by three sub-systems of care and two service modalities. The three sub-systems include: Juvenile Justice, Child Welfare, and Special Education. The service modes that cover all of the systems are the outpatient program and case management. As noted, within each sub-system is an array of services. The chart on the next page outlines this array of services across the sub-systems.

In addition to the system of core services provided in conjunction with Mental Health, there are other services and programs offered by the major public child-serving agencies. Although Mental Health is not directly involved in all service delivery, the CASSP principles are evident in each agency. This section focuses on those services with which Mental Health is involved.

Prevention

While the Ventura County system focuses on the most high-risk youth, it has undertaken a primary prevention program for young children. The Primary Intervention Program (PIP) is a school-based program modeled after the highly successful and well-researched Primary Mental Health Project in Rochester, New York. It is designed to help students settle into the school environment by assisting young children (grades kindergarten through third) who are experiencing difficulties in peer relationships, are shy, are overly active in the classroom, or have learning problems. The program's goals are to help children get a good start in school by fostering healthy self-concepts, developing social skills, and bringing school work up to potential to prevent the need for more extensive specialized help in the future.

Once a child is accepted into the program, after screening and referral, a trained and supervised child guidance assistant dedicates 30 minutes once a week for 12 to 15 weeks to work with the child individually in a specially designed and equipped playroom. The Primary Intervention Program is funded for three years through the Mental Health Primary Prevention Fund, a fund made possible by confiscated drug monies. It is a cooperative effort between the Ventura County

VENTURA COUNTY MENTAL HEALTH CHILDREN AND ADOLESCENT PROGRAM

Array of Services

Flexible dollars can be used across programs.

Element 1.	Prevention • Consultation, Education, Information Services • Primary Prevention Project
Element 2.	Emergency Service • Outpatient Crisis Service • Genesis Outreach • Case Management • Shomair Shelter Care Interventions • Juvenile Hall Crisis Intervention (Clifton Tatum Center)
Element 3.	Outpatient • Ventura - Santa Paula - Ojai • Oxnard - Camarillo • Simi - Conejo - Moorpark • Forensic Adolescent Program
Element 4.	Enhanced Special Day Care Classes
Element 5.	Day Care • Phoenix School • Phoenix Elementary Program • VIP Day Care
Element 6.	Case Management • Countywide
Element 7.	Crisis Intervention Homes • Crisis Intervention Home (6 beds)
Element 8.	Enriched Foster Homes • Shomair Homes (25 placements)
Element 9.	Transitional Residential • Colston Youth Center (45 beds) • Santa Rose Treatment Home (4 beds)
Element 10.	Acute Psychiatric Hospital • Adult Inpatient (children, adolescents integrated with adults) • Contract Arrangement with Private Psychiatric Hospitals
Element 11.	Long-Term Residential • Private Title AFDC Group Homes -- Within and Out-of-County
Element 12.	Secure Regional Intensive Treatment Center • Camarillo State Hospital, Child and Adolescent Program (6 beds)

Mental Health Department, the state Department of Mental Health, and the school districts. Currently, there are four school districts and a total of 12 schools involved in the program serving 576 children. It is anticipated that in 1992-93, the program will be expanded to additional schools and another school district resulting in approximately 672 children being served in Ventura County.

Intensive Short-Term Intervention

- **Project Genesis** is a home-based crisis service which is operated by Interface, a local, nonprofit social service agency, through a contractual arrangement with the Ventura County Mental Health Department. This intensive intervention program intervenes with families in which the emotional and behavioral problems exhibited by one or more of the children have escalated into an acute crisis and out-of-home placement is imminent.

  Services are delivered primarily in the family's home over the course of six weeks. In addition to the average of 12 to 15 hours per week of contact, each family is provided 24-hour emergency on-call services from the program and a two-week transition process into ongoing care. The program, in existence since 1986, has been providing services to over 50 families each year. Referrals are restricted to acute crises where out-of-home placement is the only available option, and the intervention is coordinated by the children's mental health supervisor in each of the child-serving sub-systems. Initial contact with the family is made by the program within 24 hours.

- **Clifton Tatum Center (CTC)** - Mental health services at Juvenile Hall comprise six-day-a-week coverage for crisis intervention and suicide risk assessment. Each youth entering Juvenile Hall is assessed by the corrections services staff as well as the medical staff, and these written assessments are reviewed by Mental Health. At that time, mental health issues are identified and followed up by mental health staff. Youth on suicide status are seen daily by Mental Health. Staff may also refer youth to Mental Health, and youth themselves can request to see mental health staff. Mental health staff provide ongoing consultation and informal training to corrections services as well as to school staff at the Clifton Tatum Center. Although there is no in-depth therapy for youth at CTC, due to their vulnerability at the time of incarceration and the excessive stress of incarceration, there is a great need for ongoing evaluation and support for some of the youth during their stay at Juvenile Hall.

Outpatient Services

- **The Options Program** - Outpatient services are provided solely by the Mental Health Department and are organized on a regional basis. During the evolution of the Ventura Planning Model, the outpatient service system of the Department has been dramatically changed. The hallmark of Ventura's outpatient delivery system is its integration with the other service systems and its focus on the target populations. As indicated in the diagrams on pages 17, 18, and 21, outpatient services are one of the treatment components of the Juvenile Justice, Child Welfare, and Special Education sub-systems of care. In addition, the Options Program is the primary source of entry and emergency contact for the community at large.

Using the Ventura County functional assessment criteria shown on page 11, the outpatient service staff, through a combined system of phone and in-person screening, assess the client's situation. A triage committee then decides whether to accept the client or refer elsewhere. Approximately 70 to 80 percent of those screened are referred to other agencies or practitioners for service. If the client is accepted for service, services could include individual and family treatment in an office setting or in the youth's home, parent consultations, and consultation and collaboration with other agency staff.

Despite these changes in doing business, outpatient services in Ventura remain in transition. Staff struggle with turning away clients who could benefit from service but who do not meet the criteria for the target population. The number of families who are accepted for service and the extent of their needs still outstrip capacity. Administrative and service staff are grappling with multiple dilemmas: how to balance the need for increased intervention against whether to serve more families at a less intense rate; the optimal length and intensity for intervention; and what types of intervention are most effective.

o **Forensic Adolescent Program (FAP)** - The FAP program was originally implemented through grant funding from the state Office of Criminal Justice Planning and was designed to provide juvenile sex offender treatment on an outpatient basis. After the three-year grant funding expired, Ventura County Mental Health incorporated the two FTE positions into the children's mental health program. This program provides specialized, primarily community-based treatment to adolescents on probation for "hands on" sex offenses. There are approximately 30 to 35 clients in the program at a time receiving treatment services, ususally for 12 to 18 months. Individual, group, and family therapy are provided on a weekly basis, and the therapy approach has a strong cognitive behavioral and psychoeducational emphasis. The FAP staff also provide evaluations to the court concerning clients' amenability to treatment, risk, and placement needs. Not all of those youth enter the FAP program, although a high percentage do. The mental health staff work closely with the probation officers assigned to the individual youth.

Day Treatment

o **The Phoenix Program** - The Phoenix School and Phoenix Elementary Program are the joint Mental Health/Special Education day treatment programs in operation in the county. The administrative authority for the program derives from the Superintendent of Schools and the Director of Mental Health. A record system that meets the regulatory requirements of Special Education and the quality assurance standards of Mental Health has been established. This system has also successfully dealt with the issue of confidentiality. Phoenix School is co-administered by a principal and a mental health supervisor. A child must be identified through the P.L. 94-142 process and have an IEP to qualify for the program. In addition, other classroom and school-based alternatives must be tried before a placement can be made in day treatment. Referrals can emanate from any district in the county. A mental health case manager coordinates placement and available services to meet client needs. A total of 24 children are served at a time.

The Phoenix program, which is based on an adaptive skills acquisition philosophy, is intensive and time-limited to one year. Each class is limited to eight students. Education and mental health staff provide a combined program of special education and treatment designed to meet the individualized goals established for that student in the IEP. Regular team meetings ensure a coordinated approach. Mental Health may provide individual, group, and family therapy, crisis intervention, support, and linkage with other services and agencies in the community. Staff meet with families at least twice a month either at the home or at school. During the summer months an extended school program is also offered.

One of the goals of day treatment is reintegration and transition back to the student's neighborhood school. At six months, Phoenix staff meet with staff in the child's school district to examine the range of options for the student and to work out a transition plan. Three months prior to the year's completion, a youth may "transition" back to his or her school for a partial day, either to a special education or regular class. A resource specialist works with the teacher to provide training and assistance with the reintegration. Mental Health may also stay involved with the youth through the case management and outpatient service modalities.

o **Enhanced Special Day Class** - These special classrooms on neighborhood school campuses offer special education and mental health services for approximately 72 children who are seriously emotionally disturbed. Interventions for youth in these classes include the services of a psychiatric social worker, a consulting psychiatrist, and case manager; family meetings and agency liaison are also provided. In addition to the special education curriculum, the mental health dimension includes four components: direct therapeutic intervention (i.e. individual, group, and family therapy); consultation to the classroom teacher; collaboration between mental health, special education and regular education staff; and coordination with other agencies. Youth assigned to these classes can participate in school activities and are often mainstreamed into regular classes when appropriate.

- **VIP Day Care** - The Visions Interagency Program (VIP) is a special school developed by the Corrections Services Agency, Children's Protective Services, county schools, and Mental Health to fill a gap in the continuum of care for high-risk youth. The school operates three days a week and also provides assistance with job training and job hunting. Staff from all four agencies working at VIP are on site and available to both court dependents and wards on a regular basis. These students attend school, have group and individual therapy, and are involved in an independent living skills curriculum as well as a number of recreational and community activities. There are up to 16 students on site, and students generally are in the program for approximately two semesters. Follow-up and ongoing mental health services are provided to students upon graduation. The goal is to help the youth and their families stabilize so that the least restrictive placement can be maintained. The majority of wards at VIP come from the Colston Youth Center, although other youth on probation may also be referred.

Foster Care Homes and Crisis Shelter

The child welfare system includes a range of foster care options for youth in custody or undergoing evaluation. Three types of foster care homes are used in the system: shelter (temporary protective custody), regular foster care for youth in the custody of the state, and enriched foster care. Shomair staff provide a mental health component to this system. In Ventura County, an average of 35 youth are referred into the shelter program per month; 325 are in foster placement; and an average of 28 are in enriched foster homes.

- **Crisis Intervention Homes** - Emergency shelter care is provided for those youth who have been referred to Protective Services for custody. The focus of the crisis intervention shelter care is on stabilization and assessment. Every child taken into custody is seen by a mental health worker within 72 hours. The foster care parents, mental health worker, and child welfare worker act as a team to provide support, comfort, and counseling to the youth, while at the same time assessing the child and family situation in order to develop recommendations for the custody hearing and for future treatment planning. A shelter foster family may have three to four youth in the home at any one time. The length of stay in shelter care is a maximum of 30 days. For three days every six weeks, respite is provided for the shelter parents.

- **McAvoy House** - In early 1989, because of a severe shortage of shelter homes to adequately serve the number of children taken into protective custody, a six-bed crisis care home, McAvoy House, was established. This home, jointly funded by Interface and the Ventura County Children's Project, provides a structured therapeutic environment, a setting for observation and evaluation, and respite for children in crisis in their own homes, in enriched foster care, or in group homes.

- **Enriched Foster Care** - Ventura County's enriched foster care program, also referred to as Shomair, is often called therapeutic foster care in other communities. The Shomair homes are part of the network of foster homes in Ventura's child welfare system, but added support is provided by mental health professionals to the foster parents and child in each home. In tandem with child protective service staff, seven MSW Shomair workers (a supervisor and six therapists), all with child welfare knowledge, work with approximately 25 foster families and the children placed with those families. Each worker has a range of four to ten cases. This staff also provide the evaluation and support to the youth in shelter care and conduct approximately 35 assessments per month. A Shomair worker may be called in to work with a child in regular foster care who is having special difficulty. In these cases, the Shomair worker might provide the extra support a child needs or recommend other treatment options.

  In enriched foster care, the social worker's role is "to stick with the child" throughout placement and to provide six months of follow-up care and support when the child returns to his or her family. The Shomair worker visits the foster family and child weekly to provide consultation and support to the foster parents, who are considered to be the child's primary therapists. Staff are also available to families 24 hours a day on an on-call basis. One Shomair staff person has been dedicated to recruitment, orientation, and in-depth training of foster parents. In addition, trainee support groups for foster parents are held. Shomair foster parents receive a higher rate of pay ($702 per month) than regular foster parents, who receive $485 a month, to compensate for the more intensive work with the child.

- **Youth Crisis Services and Cool Homes** - In addition to the other foster care resources, Ventura County has both crisis intervention and emergency shelter care for youth that are neither child welfare dependents nor juvenile court wards. Interface, through joint state and local funding, provides the Youth Crisis and Cool Home Programs as part of the county's safety net for children and families experiencing crisis and requiring alternative emergency shelter services.

Transitional Residential

Short-term, community-based residential care is provided to youth through the major child-serving systems. These transitional residential programs include Colston Youth Center for youth in the custody of the Juvenile Court and Santa Rosa Treatment Home.

- **Colston Youth Center** is a 45-bed, medium security, residential facility, offering a program that balances issues of treatment and security needs. A telephone screening is conducted with the investigating probation officer, and information regarding the suitability of a youth for Colston is incorporated into the court report. Colston serves youth ages 13 to 17 who have a lengthy delinquency history as well as a number of mental health problems, family problems, child abuse, substance abuse, depression, and/or anxiety disorders. Youth are committed to Colston for 120-, 150-, or 180-day periods. Each youth is assigned to an interagency treatment team which consists of a social worker, a teacher, corrections services officers, a psychologist, and a probation officer. The psychologist and the probation officer serve on all three treatment teams. Each team has primary responsibility for developing and implementing each youth's individualized treatment plan. Twice-a-week meetings of the treatment team help to ensure a team consensus decision-making procedure.

The treatment approach is eclectic, and includes behavior modification via a point and level system, group and family therapy, some individualized therapy, peer counseling, and a positive peer culture environment. Colston staff feel it is essential to have families involved, and every other week, families participate in family therapy sessions either individually or in a multifamily group. A high percentage of youth in the program have substance abuse problems; while no substance abuse treatment services are provided, members from Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous come in weekly offering three support groups for residents. Residents may also gain access to outside support groups during their Colston stay. The general issues that all interagency staff at Colston emphasize with the residents are skill building, particularly in effective communication skills, victim awareness, empathy building, community service, anger management, peer pressure, impulse control, and responsibility and accountability for their actions. The county's Juvenile Court judge views Colston as a "transformed juvenile correction facility," a preferred alternative to committing youth to the California Youth Authority and a way to involve families.

One full-time staff member is responsible for most of the aftercare for Colston residents. Six weeks prior to a youth's release, an aftercare meeting is held to develop a plan for the youth's post-release care. The aftercare mental health staff work with the youth, the family, the school, and probation officer to ensure that the plan is carried out. If not assigned to the aftercare case manager, youth and their families may return to Colston to continue services with the Colston social worker or may be referred to the Options Program or other private therapists in the community. Youth might also transition to the VIP program to receive mental health services there.

- **The Santa Rosa Treatment Home**, operated by Parents and Friends of Mentally Ill Children (PAFMIC) under contract with the Mental Health Department, is a four-bed intensive treatment, socialization, and rehabilitation transitional residential group home serving four severely emotionally disturbed youth, ages 6 to 18. Using a parent-teaching model, the primary goals of the program are to provide a placement alternative to admission to the state hospital; provide a transitional program for youth exiting the state hospital, private psychiatric hospitals, and other more restrictive residential treatment programs; pursue family reunification whenever possible by involving family members in family therapy; provide ongoing family-oriented treatment planning, socialization, and rehabilitative activities; and discharge clients to a lesser level of care (foster home, family or relatives). The home is staffed by two full-time live-in parents, a one-half time social worker, and a six-hour-per-week child psychiatrist. The children placed in the home attend public school (regular education, special education or the Department's day treatment/special education program) and spend every other week with their biological family.

Long-term Residential

Long-term residential care is provided in group homes that are funded through Aid for Families with Dependent Children-Foster Care (AFDC-FC). These homes are located both in and out of the county. In California, there is tremendous concern about the alarming cost of group home placements. According to a recently published report, Ten Reasons to Invest in the Families of California, in 1988-89, 11,100 youth were in group home placements in California, costing a total of $728 million or an annual cost per child of $31,000. Group home facilities vary considerably from those that are relatively small in size (4 to 10 beds) to those with over 100 beds. A group home facility is defined by the Department of Social Services as "a nonsecure, privately operated residential home of any capacity, including a private child care institution, that provides services in a group setting to children in need of care and supervision, and which is licensed as a community care facility by the department". Through Fiscal Year 1990, group homes were classified according to four models:

- Family - These homes are primarily designed to provide socialization for children who do not display age-appropriate social and relationship skills. Little or no psychiatric or psychological services are provided.
- Psychiatric - These group homes are primarily designed to treat children with diagnosed psychiatric problems. Full-time staff provide direct psychiatric services to all children in the facility.
- Psychological - These are intended to treat underlying emotional and psychological problems of children and families and to address behavioral issues. Part-time staff provide direct psychological services to children.
- Social - These homes treat children exhibiting social/behavioral problems who do not evidence marked emotional problems. Part-time staff provide direct psychological services to some children in the home.

According to the report cited above, statewide, approximately 70 percent of the youth in group homes are placed because of parental neglect, incapacity, or absence. The remainder are placed because of sexual or physical abuse. In 1987, 70 percent of children placed in group homes resided in the homes categorized as either psychiatric or psychological; but according to estimates, only 10 percent of all children in group homes in California actually received services from local departments of mental health.

Inpatient Care (Acute and Long-term)

Inpatient care is seen as a last resort placement. The Ventura system is designed to provide a range of less restrictive options and has no adequate acute psychiatric hospital for children and adolescents. When acute hospitalization is needed for children, they must be placed in an adult inpatient unit with one-to-one supervision or into two contracted beds at private psychiatric hospitals. These beds and their availability are managed by one of the children's services supervisors. For long-term placements, Ventura has placement slots (6 beds) at Camarillo State Hospital.

Specialized Services

The purpose of the Community-Based Residential Alternatives (CBRA) program is to provide seriously emotionally disturbed youth and their families with flexible dollars or staff resources for wraparound services that will enable youth to remain in their communities and attend school. A case manager is integral to program planning and coordinates the flexible services. Support services can include: respite care, enhanced supervision, behavior specialists, recreational therapy, a special friend, and peer support. If, for example, it is determined that a child in a therapeutic foster home requires greater supervision than is presently being provided, CBRA provides the mechanism for obtaining the additional funding needed for the supervision, thereby maintaining the child in the setting. Were this mechanism not available, the child might be moved to a more restrictive and expensive setting.

VII. SYSTEM LEVEL COORDINATION MECHANISMS

Background

Formal and informal mechanisms for coordination and collaboration exist at the policy, service planning, treatment, and case planning levels. This commitment to collaboration originated with top leadership, but mechanisms currently are in place at multiple levels. The structures for planning and problem resolution that have been created, and the trust that eventually has developed from working together, have been critical elements to the system's effectiveness and continuation. The Ventura Children's Project began as a collaborative effort emanating from a member the Board of Supervisors, a juvenile judge, and the Director of Child Mental Health making a commitment to improve services to the most disturbed children in the county. The member of the Board of Supervisors, an elected official, had the sanction and the clout to pull together the executives of the key child-serving agencies for regular meetings. These meetings, which began as brown bag lunches in the office of the Supervisor, launched the approach. Few other states and communities have put as many of the critical elements together to undertake such a systematic evaluation -- the collaboration between the public and academic sectors, the expertise of the research staff, the systemic measures, the data collection mechanisms, the cross-systems collaboration, and the funding support for such research.

XII. MAJOR STRENGTHS AND CHALLENGES

Major Strengths

The Ventura project has served as a leader and forerunner for the development of local systems of care for children and adolescents who are severely emotionally disturbed. When many national experts in the children's services field were merely talking about the need for a new approach to serving troubled children and families in this country -- an approach that would involve interagency coordination and collaboration, a comprehensive array of services, and community-based care -- Ventura was working to operationalize these concepts. The country has learned a great deal from the Ventura experience. A number of initiatives, including CASSP and the Robert Wood Johnson Foundation's Mental Health Services Program for Youth, have looked to Ventura for guidance in the development of local systems of care. States and communities across the country have studied the Ventura Planning Model in their own efforts to develop systems that are appropriate to their environments.

The Ventura experience is not only about creating a system of care; it is about creating systems change. Ventura staff have tremendous knowledge about what it takes to change systems and to implement a system of care. They have had over eight years of experience in building trust, testing assumptions, and restructuring institutions. They have been successful, because the strengths Ventura has developed dovetail well with the crucial elements necessary for systems change. These critical elements include the following:

- **Leadership** - The importance of leadership cannot be underestimated. Ventura has demonstrated an understanding of the value of obtaining and fostering multiple sources of leadership to develop a power base of support. Much of the credit for Ventura's success is due to the vision, leadership, and skill of the current Director of the Ventura Mental Health Department, who has been involved with Ventura Mental Health since the early 1980s. However, he could not have been successful in creating systems change without strong support from other key leaders -- in Ventura County, this meant the Board of Supervisors and the judges. Individuals from both these arenas were willing to take risks and bring others together to explore ways to serve youth differently. Leadership and support at the state level, in the legislature and the California Department of Mental Health, were also essential to make the necessary legislative and administrative changes to enable the state and county to move in new directions.

In addition to leadership at the top levels, strong leadership at the agency level is also critical to implementing a good idea. Ventura has worked to encourage and sustain leadership at this level as well. When the former Director of the Children's Demonstration Project took over the director's position of the Mental Health Department, a key staff member, who had been involved in the early stages of Ventura's development, assumed the leadership of the children's system, continuing to provide able direction and continuity in carrying out the mission. Other agency staff in management positions have also provided stability, competent leadership, and vision.

- **Vision and Clarity of Goals** - The Ventura project has had a strong philosophical underpinning and vision from the outset. The message is clearly stated; it is consistent; and it makes sense. The core value for Ventura is that a community-based, interagency system of mental health care which targets the most disturbed children will provide the greatest benefit to children, their families, and the community at the lowest cost to the public sector. This mission statement and the essential elements of the Ventura model drive all the activities of the system and, over time, have permeated all levels. While there have been some pressures to broaden the population or focus less on costs, Ventura has remained steadfast to its goals.

- **Planning** - The leaders of Ventura understand planning and are highly skilled strategic planners. They believe in and have operationalized a planning model to achieve goals for mental health care reform. This Planning Model includes defining a vision, targeting the populations to be served, determining the outcomes to be achieved, establishing what mental health services are needed to enable the target population to achieve these outcomes, determining what resources are necessary to provide these services, forming coalitions to garner these resources, and collecting data for evaluation, system accountability, and marketing purposes. Ventura has been consistent in its dedication to implementing these strategies.

- **Meaningful Collaboration** - From the outset the Ventura mental health staff was committed to working with other child-serving agencies. Mental health staff physically go to or work in these agencies and become part of the environment and culture of these service systems. Staff of Mental Health, Special Education, Child Welfare and Juvenile Justice work together as teammates. Not only do they collaborate around clients, but they share discussions at the water fountain or over lunch. There are good lines of communication and a high degree of mutual respect and trust. There are also numerous mechanisms at multiple levels that provide a forum for discussion and problem solving -- the Interagency Juvenile Justice Council, the Case Management Council, and the various interagency screening committees. A number of individuals mentioned that as a result of this experience with interagency collaboration, "The whole is much greater than the sum of its parts." Staff admit they could never return to the old way of doing business.

- **Dedicated Staff** - The Ventura project has changed how mental health staff provide treatment, and, for the most part, staff have demonstrated a willingness to make changes. They are believers in the vision. They understand system issues and are committed to collaboration. They are secure in their talents and abilities and are comfortable with the uncertainty that change often brings.

- **Service Array** - By leveraging resources, reallocating dollars, and blending funds across agencies, Ventura has been able to expand the service continuum to include an array of community-based services including home-based services, case management, therapeutic foster care, day treatment, and specialized services through the Resource Development Project and CBRA. Having this range of treatment alternatives enables the system to be responsive to youth and families and makes the system "work" for agencies trying to obtain services for clients.

- **Legislative Mandate** - One of the strengths of the Ventura system is its statutory sanction. Many of the critical elements of the system -- articulating the vision, defining the target population, requiring interagency agreements, and requiring the measurement of outcomes -- are established in law. This mandate gives Ventura the political and legal clout to implement its system of care and institutionalizes the concept of an interagency, community-based system of care.

- **Evaluation Capability and Successful Outcomes** - Because Ventura was started as a demonstration project and mandated to document cost avoidance and successful outcomes, it has set up an evaluation and tracking system which enables the mental health agency to collect data and report progress in achieving objectives. From the outset, Ventura has had a capable, competent research staff to establish and implement this evaluation system. This system for tracking system accountability and client outcomes has been enormously valuable in documenting systemic impacts and in justifying this approach to service organization and delivery. Ventura leadership believes that the data showing cost savings and client benefits are the reason for the system's survival in difficult economic times. Without this evidence, a new wave of legislators and political leadership might easily have terminated the project in search of different solutions. Instead, the Ventura system has become a model for the state and has been expanded to include the adult mental health service system. Ventura leadership maintains that outcome data are a prerequisite for any system, for future decision making, and for political and financial survival.

- **Cultural Competence** - Ventura has made a major commitment to improving cultural competence, developing a master plan, hiring staff to work with the county in implementing this plan, conducting specialized training of staff, and undertaking numerous other activities to improve services to minority groups. While many activities spelled out in the master plan are just being initiated, Ventura is on the cutting edge in this area and is taking a leadership role.

- **Target Population** - While Ventura has received its share of criticism for strictly limiting the population it services, system leaders are convinced that having a clear definition of who is to be served with limited public dollars and establishing criteria for assessment are absolutely essential to the success of a system of care. The target population dictates the services to be developed and the outcome goals to be achieved.

Continuing Challenges

While Ventura has made major progress in developing a system of care and has achieved many milestones of success, it continues to face challenges and problems.

- **Continued Funding Support** - California, like many states, is experiencing major deficits. Budgets for services are being cut back and agencies are having to serve an increasing population in need with diminishing resources.
- **Resistance to Change** - As noted, the Ventura staff, for the most part, have embraced change and are ardent supporters of reforming the system. But opposition to change exists. Revamping the outpatient service to serve only the targeted populations and to provide treatment that is radically different from a traditional community mental health center approach has been a struggle. The process is still underway, and staff are still learning how to reorganize and reconceptualize outpatient services to fit in the new system.
- **Service Development** - The continued development of community-based services and the determination of which services are most needed to fill the gaps represent a continuing challenge. Different parts of the system view the gaps and the needs from varying perspectives. Child welfare personnel see the need for more foster homes; the judges and probation officers are concerned about crowding in juvenile facilities. Other service gaps include a lack of crisis intervention, substance abuse services, and prevention and early intervention. Certain services such as home-based and case management could be expanded if there were more adequate resources.
- **Family Involvement** - How to meaningfully involve families and respect the decision making of families around appropriate care for their children is an ongoing struggle for Ventura, as it is in other communities. There are situations in which Ventura's system's goals to serve a youth close to home with community-based services and supports may conflict with the parents' assessment of what is best for the child. In these cases, Ventura staff work with families to review treatment options, taking into

consideration parents' concerns. Ultimately, it is the parents' decision. Also different sub-systems relate to families in different ways. For example, there are occasional conflicts between Shomair workers, protective services staff, and foster care parents in decisions to reunify a child with natural parents. However, because of the level of trust established and effective lines of communication, these differences typically can be worked through. Ventura could also benefit from increased parent involvement on the interagency bodies and in the development of support groups.

- **Systems Issues** - Even given Ventura's efforts to break down system barriers through interagency agreements, joint funding and decision making, and policy level negotiations, bureaucracies do not always work in the most expeditious ways. Legal mandates, court delays, burdensome paperwork, turnover of the Juvenile Court judges, and barriers to using Medicaid for incarcerated youth all represent problems brought up by staff of the various agencies in Ventura.

These are problems confronting many communities trying to establish community-based systems of care. Because Ventura has been a leader in undertaking systems reform, this county will continue to be in the spotlight to see how it addresses these complex issues, thereby serving as a guide to others.

XIII. TECHNICAL ASSISTANCE RESOURCES

Leadership and staff of Ventura County have played an active role in providing technical assistance to multiple constituencies and have generously shared their knowledge and experience in developing a community-based system of care. Staff have presented at numerous national meetings and conferences; conducted site visits for a wide range of officials including federal, state, and local administrators, providers, and foundations; and provided consultation to states and communities upon request. Ventura has also developed a wealth of materials summarizing and describing various aspects of their system. Staff work closely with other California counties and with the state to assist in replication of the Ventura model.

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